Anthem®

Health. **Join In.**

Your KeyCare Plan

SURA Jefferson Science Associates

Effective April 1, 2011

KeyCare 15 Plus

Welcome to Anthem benefits

We're glad you're taking time to check out all that Anthem has to offer you. Choosing your benefits is an important decision and this booklet is designed to help. Basically, it's a snapshot of the benefits that come with Anthem coverage. It shows what's available to you, what you get with each benefit and how the plans work.

Explore the Anthem membership advantage.

We know you're busy. That's why we've made sure it only takes a few moments to explore the advantages of being an Anthem member, including:

- There's a good chance your doctor is part of Anthem's network. To find out, go to anthem.com and search the provider directory. We also have one of the largest networks of hospitals and specialists.
- You're covered even when you're away from home. You can travel outside your area or country — and know you're covered.
- You get more than access to coverage. You also get tools, resources and guidance that may help you reach your personal, healthy best.
- Anthem.com has the answers you need. Simply go to anthem.com for answers to your claims questions and find detailed health benefit information.
- This booklet goes into all this — and more. Please take a few minutes to look over the information, and keep this booklet. It may come in handy.

Registering on anthem.com is step one.

Once you get your ID card, registering is easy; all you need is your ID card, the Internet and five minutes. After you register at anthem.com, you can tap into decision-making tools, health information and many resources. It's also the convenient way to order a new ID card, check claims status, find out the cost of services, learn about doctors and hospitals, and so much more.

- Go to Anthem.com
- Enter the site by clicking on Member
- Follow instructions to create your user name and password and you're ready to go!

Read on for information to help you choose your benefits with confidence. If you have any questions, your benefits manager will be happy to answer them. Thanks for considering Anthem Blue Cross and Blue Shield.

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Choosing a Health Plan That's Right for You

Choosing the right health plan for you and your family is a tough decision. There are so many options and so many acronyms. Although confusing, this is important. The plan you pick will affect your paycheck and your health care spending throughout the year. That's why we encourage you to carefully think about your needs and options. And we're going to help...

Know the basic differences between the plan types.

You may have a choice of health plans at work or within your family. Knowing how the different plans work will help you to pick the plan that best fits your family needs and budget.

Understand the total costs.

Benefit plans differ in many ways. But with every plan, there is a basic premium, which is how much you and your employer pay to buy coverage. The premium may only be a small part of your total cost. There are other payments you may make, which vary by plan. When considering any plan, try to figure out its total cost to you and your family, especially if someone in your family has a chronic or serious health condition. Consider the following:

- Are there deductibles you must pay before the insurance begins to help cover your costs?
- Are there office visit, emergency room or inpatient copayments you must pay?
- What percentage of the cost for other services are you responsible for? (This is known as your coinsurance amount.)
- If you use doctors outside of the plan's network, how much more will you pay to receive care?

To see the costs associated with the Anthem products, see your summary of benefits. You will notice that with an Anthem product, you can help keep your costs down by using in-network providers

Understand the benefits beyond basic coverage.

When it comes to understanding your benefits, the details are what count. The best plan for someone else may not be the best plan for you. Consider your needs for the following and determine which plan offers you the best coverage:

- Does the plan help you stay healthy with preventive care such as physical exams, immunizations and health screenings?
- Are you able to see a specialist without a referral?
- Do you and your family have coverage while traveling?
- Do any of the plans provide special programs for asthma, diabetes or other chronic conditions?

Assess your family's needs.

After you review the benefits available and determine what is most important to you, you can compare plans. Many things should be considered including services offered, choice of physicians and hospitals, costs and additional tools that can help you stay healthy. Ask some of these questions:

Choosing a Health Plan That's Right for You (continued)

- How do I feel about limits on my choice of doctors and hospitals?
- Is my doctor in the network? What about my gynecologist or child's pediatrician?
- How important is the cost of services? Am I willing to pay more to see a physician that is not in the network?
- Am I willing to pay more from my paycheck to have my health plan cover more of the services? Or buy a lower cost plan and pay a little more for services as we use them?

Get more for your money.

It's also important to think about what you expect out of your benefits plan. Consider the following:

- Does the plan offer educational materials, newsletters or online tools on healthy living?
- Does the plan offer tools to help you manage your health, as well as your benefits?
- Is there a lot of paperwork or hassle involved with the plan or does it work simply?
- Does the plan offer discounts on health-related programs and resources?

While you can't predict all of your family's needs, it pays to make a list of the services you expect to need in the coming year and then evaluate each plan according to your list. Remember to include some of the features that are important to your family that aren't related to cost, such as coverage while traveling and resources to help you manage your health.

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Your Health Benefits

Anthem KeyCare PPO Plan

With no primary doctor requirement and no referrals, you're free to make your own decisions about your health care.

The big buzz these days is that you have the power to take charge of your health. We would agree that's a good idea. That's why we build our health plans with options, resources and overall support to help you make decisions. This is a quick overview of how your plan works.

One, you have options. Anthem KeyCare is a PPO plan, which means you're free to choose your doctor without referrals. Of course, in-network care will usually cost less than out-of-network care. For many of our KeyCare plans, you'll also pay less when visiting a PCP instead of a specialist. The network includes most doctors and hospitals across the nation, so you'll find plenty of choices. The point is, the choice is yours.

Two, as an Anthem member, you have access to a lot of online tools. Helping you make your decisions is important to us, but not nearly as important as helping you make the right decisions – for you, your health and your budget.

Anthem KeyCare PPO at a glance

Primary Care Physicians (PCPs): Not required
You can make your own decisions about your doctors, your care and your costs.

Referrals: Not needed
You pick who you want to see. Makes getting second opinions very easy.

Claim Forms: No claim forms to submit when using network providers.

Out-of-Network Benefits: Available, but at lower coverage levels than in-network. We've negotiated special rates with our network doctors and hospitals on behalf of our members. By staying in-network, you can take advantage of these rates and receive higher levels of coverage.

Out-of-Pocket: This is the amount you'll pay, whether it is a straight copayment or some percentage of coinsurance for the cost of covered services.

You can see what services cost before your visit

Through **anthem.com**, you can estimate the costs for inpatient and outpatient services and doctor visits. What better way to help you determine what to do?

You're covered whenever you travel

If you're traveling in the U.S. or out of the country, your coverage travels with you. If you need emergency, urgent or approved follow-up care, you have three options. Go to **anthem.com**, call BlueCard® PPO Access at 800-810-2583 or call the customer service number on your member ID card.

How to find a network doctor

Anthem networks are some of the largest in the U.S. Simply go online and search our provider directory for the type of care you need.

1. Go to **anthem.com**.
2. Select "Find a Doctor."
3. Select your state.
4. Select the Anthem KeyCare PPO plan.
5. Select your provider type.
6. Select a specialist, if needed.
7. Enter your search criteria.
8. Click "View Results."

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Anthem KeyCare PPO Plan (continued)

You're getting more than a health plan

You get programs to actually help you manage your health. MyHealth@Anthem®, 360° Health® health management programs, and SpecialOffers@Anthem are all available through **anthem.com**. The programs are explained in detail later in this booklet.

This is a brief overview of your plan's features. Your benefits summary contains the details. Thank you for considering Anthem Blue Cross and Blue Shield.

Take care of yourself. Take advantage of your preventive care benefits.

Here's an overview of the types of preventive services covered. Refer to your benefit summary to learn more.

Regular preventive care can help you stay well, catch problems early on and may be potentially life saving. To support and surpass health care reform recommendations, our plans cover 100% of covered preventive care services[1] like screenings, immunizations and exams. If you visit in-network providers, you don't have to worry about any out-of pocket costs for preventive care services. If you use an out-of-network provider, your deductible and out-of-network expenses may apply. Please note also that if during the course of the screening, your provider detects something that requires further review and or treatment, the provider may bill the visit as diagnostic versus a screening. If that occurs, you will be responsible for the applicable member cost share.

Preventive vs. diagnostic care

What's the difference? Preventive care is generally precautionary. For example, if your doctor recommends having a colonoscopy because of your age or family history, that's preventive care. But, if your doctor recommends a colonoscopy to investigate symptoms you're having, that's diagnostic care, and your plan cost share will apply.

Please note, the preventive care services in this document are not recommended for all individuals and appropriateness may be determined by the treating physician and recommendation guidelines.

Child preventive care (birth to 18 years)

Preventive physical exams

Screening tests include:

- Vision screening[2]
- Hearing screening
- Oral health assessment
- Screening for lead exposure
- Screening for anemia
- Screening for tuberculosis
- Pelvic exam and Pap test, including screening for cervical and ovarian cancer
- Newborn screenings including sickle cell anemia
- Developmental and behavioral assessments
- Cholesterol and lipid level screening
- Screening for depression
- Screening and counseling for obesity
- Behavioral counseling to promote a healthy diet
- Screening for sexually transmitted infection

Immunizations

- Hepatitis A
- Hepatitis B
- Diphtheria, Tetanus, Pertussis (DtaP)
- Varicella (chicken pox)
- Influenza (flu shot)
- Pneumococcal Conjugate (pneumonia)
- Human Papilloma Virus (HPV)
- Hib Influenza type b
- Polio
- Measles, Mumps, Rubella (MMR)
- Meningococcal Polysaccharide
- Rotavirus

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Take care of yourself. Take advantage of your preventive care benefits.

Adult preventive care (19 years and older)

Preventive physical exams

Screening tests include:

- Eye chart vision screening[2]
- Hearing screening
- Cholesterol and lipid level screening
- Depression screening
- Diabetes screening
- Prostate cancer screenings including digital rectal exam and PSA test
- Breast exam, breast cancer screening, including mammography
- Pelvic exam and Pap test, including screening for cervical and ovarian cancer
- Screening for sexually transmitted diseases
- HIV test
- Bone density test to screen for osteoporosis
- Colorectal cancer screening including fecal occult blood test, barium enema, flexible sigmoidoscopy and screening colonoscopy
- Routine blood and urine screenings
- Aortic Aneurysm screening
- Pregnancy screenings (including hepatitis, asymptomatic bacteriuria, Rh incompatibility, syphilis, iron deficiency anemia, gonorrhea, chlamydia)
- Intervention services to include counseling and education including the following:
  - Screening and counseling for obesity
  - Counseling related to genetic testing for breast and ovarian cancer
  - Behavioral counseling to promote a healthy diet
  - Primary care intervention to promote breastfeeding
  - Counseling related to aspirin use for the prevention of cardiovascular disease
  - Screening and behavioral counseling related to tobacco use
  - Screening and behavioral counseling related to alcohol abuse

Immunizations:

- Hepatitis A
- Hepatitis B (expanded codes)
- Tetanus, Diphtheria (Td)
- Varicella (chicken pox)
- Influenza (flu shot)
- Pneumococcal Conjugate (pneumonia)
- Human Papilloma Virus (HPV)
- Measles, Mumps, Rubella (MMR)
- Meningococcal Polysaccharide
- Herpes Zoster (shingles)

1 Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits.
2 Some plans cover additional vision services. Please see your Certificate of Coverage for details.

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Your Anthem Benefits

Anthem

Anthem KeyCare 15 Plus

In-Network Services	You Pay
Preventive Care Services	
Preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits. * During the course of a routine screening procedure, abnormalities or problems may be identified that require immediate intervention or additional diagnosis. If this occurs, and *your* provider performs additional necessary procedures, the service will be considered diagnostic and/or surgical, rather than screening, depending on the claim for the services submitted by *your* provider, which will result in a member cost share.	**No charge**
Routine Vision	
o annual routine eye exam ***Plus – valuable discounts on eyewear***	**$15** for each visit
Doctor Visits	
o office visits o urgent care visits o home visits o pre- and postnatal office visits** o in-office surgery o physical and occupational therapy in an office setting (30 combined visits)* o speech therapy visits in an office setting (30 visit limit)* o spinal manipulations and other manual medical intervention visits (30 visit limit)* * Limited to 30 combined visits per calendar year for physical therapy and occupational therapy services, and 30 separate visits each per calendar year for speech therapy and spinal manipulation services. ** If your physician submits one bill for prenatal, delivery, and postnatal care, services are covered as maternity delivery services. (See Inpatient stay section.)	**$15** for each visit to a family or general practitioner, internist or pediatrician **$30** for each visit to a specialist
Labs, X-rays and Other Outpatient Services	
o lab services o Pap tests o Prostate Specific Antigen (PSA) tests o screening tests o infusion services o shots and therapeutic injections o dialysis o chemotherapy o radiation and respiratory therapy	**No charge**
o diagnostic x-rays	**$30** for each visit*
o advanced diagnostic imaging services ***Your payment responsibility is waived if services are billed as part of an emergency room visit.***	**$150** for each visit*
o medical appliances, supplies and medications, including infusion medications o durable medical equipment o professional ground ambulance services	**20%** of the amount of the health care professionals in our network have agreed to accept for their services
Outpatient Visits in a Hospital or Facility	
o physical therapy and occupational therapy (30 combined visits)* o speech therapy (30 visit limit)* * Limited to 30 combined visits per calendar year for physical therapy and occupational therapy services, and 30 separate visits each per calendar year for speech therapy and spinal manipulation services.	**$30** for each visit
o emergency room o surgery ***For the services billed by the doctor, you will pay an additional $15 or $30 depending on the type of doctor who treats you.***	**$150** for each visit
Mental Health and Substance Abuse Outpatient Services	
o office visits	**$15** per visit/PCP or **$30** for Specialist visits
o outpatient facility (including partial day treatment and intensive outpatient programs) o outpatient facility professional provider services	**$30** per facility visit plus $15 per PCP/$30 Specialist visit in an outpatient facility

For benefits listed with specific limits all services received during the calendar year from January 1 and December 31 for that benefit are applied to that limit (whether received in or out-of-network).

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In-Network Services	You Pay
Care at Home	
o home health care visits by a nurse or aide (90 visits)	**20%** of the amount the health care professionals in our network have agreed to accept for their services
o hospice care	**No charge**
o private duty nursing ($500 maximum)* ***Since there is no network for this service, you may be billed for the difference between what we pay for this service and the amount the private duty nursing service charged.***	**20%** of the amount the health care professionals in our network have agreed to accept for their services
Inpatient Stays in a Network Hospital or Facility	
o semi-private room, intensive care or similar unit ***You do not have to pay another $300 if you are readmitted within 90 days of the day you went home.***	**$300 plus 20%** for each admission*
o physician, nursing and other medically necessary professional services in the hospital including anesthesia, surgical and maternity delivery services o skilled nursing facility care (100 days for each admission) ***If your physician submits one bill for prenatal, delivery, and postnatal care, services are covered as maternity delivery services.***	**20%** of the amount the health care professionals in our network have agreed to accept for their services

Out-of-Network Services

Using Doctors, Hospitals and Other Health Care Professionals not Contracted to Provide Benefits

It's important to remember that health care professionals not in our network can charge whatever they want for their services. If what they charge is more than the fee our network health care professionals have agreed to accept for the same service, they may bill you for the difference between the two amounts. You will pay all the costs associated with the covered services outlined in this insert until you have paid $400 in one calendar year. This is called your out-of-network deductible.

- If two people are covered under your plan, each of you will pay the first $400 of the cost of your care ($800 total).
- If three or more people are covered under your plan, together you will pay the first $800 of the cost of your care. However, the most one family member will pay is $400.

Once you have reached this amount, when you receive covered services we will pay 70% of the fee our network health care professionals have agreed to accept for the same service. You will pay the rest, including any difference between the fee our network health care professionals have agreed to accept for the same service and the amount the health care professional not in our network charges. If you go to an eye care professional not in our network for your routine eye examination, we will pay $30 (whether or not you have reached the $400 out-of-network deductible) and you will pay the rest of what the professional charges.

Out-of-Pocket Maximums

What You Will Pay for Covered Services in One Calendar Year (January 1 - December 31)

When using network professionals

If you are the only one covered by your plan, you will pay $2,000 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is $0, except for those services listed below that do not count toward the annual out-of-pocket maximum*.

- If two people are covered under your plan, each of you will pay $2,000 ($4,000 total).
- If three or more people are covered under your plan, together you will pay $4,000. However, no family member will pay more than $2,000 toward the limit.

When not using network professionals

If you are the only one covered by your plan, you will pay $4,000 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is $0, except for those services listed below that do not count toward the annual out-of-pocket maximum*.

- If two people are covered under your plan, each of you will pay $4,000 ($8,000 total).
- If three or more people are covered under your plan, together you will pay $8,000. However, no family member will pay more than $4,000 toward the limit.

***The following do not count toward the calendar year out-of-pocket maximum:**

- your share of the cost of prescription drugs and routine vision care
- the cost of care received when the benefit limits have been reached
- the cost of services and supplies not covered under your Anthem KeyCare 15 Plus plan
- the additional amount health care professionals not in our network may bill you when their charge is more than what we pay

This benefits overview insert is only one piece of your entire enrollment package.
See the enrollment brochure for a list of your plan's exclusions and limitations and applicable policy form numbers.

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

Anthem Blue Cross and Blue Shield believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections of the Affordable Care Act apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Anthem Blue Cross and Blue Shield at the telephone number printed on the back of your member identification card, or contact your group benefits administrator if you do not have an identification card. For ERISA plans, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1–866–444–3272 or www.dol.gov/ebsa/healthreform. This Web site has a table summarizing which protections do and do not apply to grandfathered health plans. For nonfederal governmental plans, you may also contact the U.S. Department of Health and Human Services at www.healthcare.gov.

Coverage for Domestic Partners

Your group has chosen to add coverage for domestic partners, as defined by your group's eligibility requirements. This coverage expands the definition of eligible dependents that is indicated on page 12 of your Anthem KeyCare enrollment brochure MVABR6790A (07/09)] or Anthem BlueCare enrollment brochure [MVABR6789 (07/09)]. For more information about domestic partner eligibility requirements, please contact your group benefits administrator.

This insert is only one piece of your enrollment package. Exclusions, limitations and other related provisions can be found in the enrollment brochure.

Morbid Obesity Coverage

Your group has chosen coverage for morbid obesity services that deviates from the exclusion listed on page 22 of your Anthem KeyCare enrollment brochure [MVABR6790A (07/09)] or Anthem BlueCare enrollment brochure [MVABR6789 (07/09)].

Treatment of morbid obesity coverage is covered through gastric bypass surgery or such other methods as may be recognized by the National Institutes of Health as effective treatment for the long-term reversal of morbid obesity for a patient who:

- Weighs at least 100 pounds over or twice the ideal body weight for frame, age, height and gender as specified in the 1983 Metropolitan Life Insurance tables;
- Has a body mass index (BMI) equal to, or greater than, 35 kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea or diabetes; or
- Has a BMI of 40 kilograms per meter squared without such comorbidity.

Coverage does not include weight control dietary supplements or weight loss medications, unless such supplements or medications are recognized by the National Institutes of Health as effective treatment for the long-term reversal of morbid obesity for patients meeting the requirements specified above.

This flyer is a summary of the benefits available to members under the optional Anthem Morbid Obesity benefit. This insert is only one piece of your information package. Exclusions, limitations and other related provisions can be found in the enrollment brochure.

Coverage While Traveling

Whether you're traveling on business, away for fun or have been stationed in another state, your coverage travels with you. The BlueCard® program makes sure of that by uniting Anthem's network with those of other Blue Cross and Blue Shield companies across the U.S. You'll have access to medical care most anywhere you're staying.

It's as easy as accessing your local network.

Getting medical care away from home is as convenient as accessing the local network — with just one added step.

1. Find a provider from the BlueCard listing. Like when at home, you can search online at anthem.com or call the member services number on the back of your member ID card. You can also call BlueCard Access at 800-810-BLUE (2583).
2. (This is the additional step.) Call Anthem member services to verify your coverage.
3. Show your ID card at the time of service.

One additional step. No additional costs or hassles. You pay the same with any Blue Cross and Blue Shield provider as you would an Anthem network provider. Plus the provider will file your claims for you. Anthem will still mail your explanation of benefits so you can double check how the service was covered.

As always, if you need emergency care, you should go to the nearest hospital without contacting Anthem first. Just give us a call within 24 hours or as soon as reasonably possible.

Enjoy your travels. We're happy to go with you.

Your prescription drug benefits

Pharmacy network

Anthem's prescription drug program manages more than 400 million prescriptions each year.
With a broad retail pharmacy network, home delivery and a specialty unit that dispenses high-cost, biotech therapies, our comprehensive approach helps you manage your pharmacy benefits.

Some members have a tiered drug list/formulary, or list of covered medications, which assigns drugs to specific tiers based on cost. Tier 1 drugs have the most affordable copay. Tier 2 drugs cost slightly more, and Tier 3 drugs have the highest copay amounts.

Your Prescription Drug 8-15-30 Plan	Tier 1 Copay	Tier 2 Copay	Tier 3 Copay
Up to a 30-day medication supply at participating retail pharmacies	$8	$15	$30
Up to a 90-day medication supply delivered to your home	$8	$30	$90

Retail pharmacies

Our retail pharmacy network includes more than 62,000 pharmacies throughout the United States. That means you have convenient access to your prescriptions wherever you are – at home, work or even on vacation. To find out if your pharmacy participates in our network, contact Customer Care at the phone number listed on your member ID card. Or, visit **anthem.com** for a list of participating pharmacies.

Most plans allow you to get up to a 30-day supply of covered medications at a retail pharmacy.

Simply show your ID card at the pharmacy and pay the appropriate copay.
You'll get the most from your benefits by using a participating retail pharmacy. Choosing a non-network pharmacy means you'll pay the full cost of the prescription. Then, you must submit a claim form to our pharmacy program for reimbursement, based on your benefit.

Home delivery pharmacy

Home delivery is for people who take medications on an ongoing basis. Our preferred home delivery pharmacy, operated by Express Scripts, delivers the medications you need, right to your door. You can easily refill home delivery prescriptions by phone, fax, mail or online. And, view benefit information 24/7 at **anthem.com.**

As a home delivery customer, you'll also enjoy:

- Free standard shipping
- Personal prescription counseling
- Direct access to licensed pharmacists
- Our 99.99 percent accuracy rate plus multiple safety checks by licensed pharmacists
- Experienced Customer Care associates to answer benefit questions

Switch and save

Plus, you may even save money. Here's an example:

If you have a $20 copay:

- Pay $60 for a 90-day supply at a retail pharmacy.
- Pay $40 for the same 90-day supply, using home delivery.

Your prescription drug benefits

- The savings can really add up, especially if you're taking multiple medications. Plus, we dispense money-saving generic medications unless you or your doctor request otherwise.

Getting started with home delivery

Switching to home delivery is simple. Choose from one of the following methods:

- **By phone:** Call **866-281-4279**, Monday through Friday, 8:30 a.m. to 8 p.m., Eastern time, to get your free cost-savings estimate. You'll find out how much your prescription will cost and how much you'll save. *Be sure to have the following information handy:* prescription information, doctor's name, phone number, medication names/strengths and credit card information (including cardholder name, account number and expiration date).

- **By mail:** To get an order form, call the Customer Care number on your member ID card. Or, download a form from **anthem.com.** Print the form and mail your completed order form, original prescription and payment information to:

  Home Delivery Pharmacy
  PO Box 66785
  St. Louis MO 63166-6785

- **By fax:** Have your doctor fax your prescription information to 800-600-8105. The prescription must be faxed directly from your doctor's office. If there is a question about your prescription(s), we'll contact your doctor.

Ordering home delivery refills

With home delivery, you don't have to worry about running out of medication. That's because we'll call to let you know when you're running low. You can easily reorder by phone, online or by mail:

- **By phone:** Have your prescription label and credit card ready. Call **866-281-4279** and select the "Automated Refill Order Line" option from the menu, or press zero at any time to speak to a care coordinator. If you are speech or hearing impaired, call **800-899-2114.** Follow the prompts to place your order.

- **Online:** Go to **anthem.com**, log in and click on the Refill a Prescription link.

- **By mail:** Complete an order form you received with a previous order. Affix your label or write the prescription refill number in the area provided. Mail the order form with the proper payment to:

  Home Delivery Pharmacy
  PO Box 66785
  St. Louis MO 63166-6785

Specialty Pharmacy

Specialty medications are the fastest growing segment of U.S. drug spending today. These breakthrough biotech drugs are revolutionizing care for people with these medication needs. CuraScript, the Express Scripts specialty pharmacy, offers a robust, personalized support program for people with chronic and complex conditions. These conditions may include, but aren't limited to:

- Asthma
- Cancer
- Crohn's Disease
- Gaucher's Disease

Your prescription drug benefits

- Hemophilia
- Hepatitis C
- HIV/AIDS
- Infertility
- Multiple sclerosis
- Primary immune deficiency
- Psoriasis
- Pulmonary arterial hypertension
- Rheumatoid arthritis
- Respiratory syncytial virus (RSV)
- Transplant

Patient care advocates, registered nurses and clinical pharmacists work together to provide disease-specific care management. They'll coordinate specialty pharmacy activities to help improve the quality and cost of care. And, they'll do everything they can to help you achieve the best possible outcomes from your treatments.

Ordering specialty medications

You can order specialty medications by phone or fax:

- **By phone:** Call **800-870-6419** to verify your information. Patient care advocates are available Monday through Friday, 8 a.m. to 10 p.m., Eastern time.

- **By fax:** You can have your doctor fax your prescription(s) and a copy of your ID card to **800-824-2642**.

Drug list/formulary

Anthem's drug list/formulary is a list of brand and generic medications that are approved by the U.S. Food and Drug Administration (FDA) and covered by your plan. We're committed to providing you with access to quality medications at a price you can afford. Through detailed research, we find drugs with the highest success rates that also help lower the cost of care.

Our Pharmacy and Therapeutics (P&T) Committee then reviews and selects these medications for their safety, effectiveness and value. The P&T Committee includes a large group of doctors and pharmacists who are not employees of Anthem Blue Cross and Blue Shield. This group and other professionals are responsible for the decisions surrounding our drug list/formulary.
Medications on the drug list/formulary are subject to periodic review. To view the current list, visit **anthem.com**. Click on Customer Care in the top-right corner. Select your state, then click on Download Forms. You'll find the drug list in the Forms Library. You can also call the phone number on your member ID card to check a specific drug.

Generic medications

Our drug list/formulary includes money-saving generics, as well as brand medications. By choosing a generic, you get the same effect as the brand drug – but normally at a lower cost.
Generic and brand drugs have the same active ingredient, strength and dose. The FDA requires generics to meet the same high standards for purity, quality, safety and strength.
Even though the active ingredient of a generic is identical to its brand counterpart, manufacturers may use different inactive ingredients. This could affect the color, shape and size. But because generics must meet the same FDA standards as brand drugs, you can feel confident the generic is just as safe and effective. Ask your doctor if a generic is right for you.

Your prescription drug benefits

Prior authorization

Most prescriptions are filled right away when you take them to the pharmacy. However, some drugs need our review and approval before they're covered. This process, called prior authorization, helps ensure drugs are used as recommended by the FDA. Prior authorization focuses mainly on drugs that may have:

- Risk of serious side effects or dangerous drug interactions
- High potential for incorrect use or abuse
- Better alternatives that may cost you less
- Restrictions for use with very specific conditions

If your doctor prescribes a drug that requires prior authorization, we'll send an electronic notice to your pharmacy. This lets the pharmacist know that additional health information is needed for review. By monitoring the use of certain drugs, prior authorization helps keep you safe and make your medications affordable. To check if your medication requires prior authorization, visit **anthem.com** or call the number on your member ID card.

Anthem Blue Cross and Blue Shield receives financial credits from drug manufacturers based on total volume of the claims processed for their product utilized by Anthem members. These credits are retained by Anthem as a part of its fee for administering the program for self-funded groups and used to help stabilize rates for fully-insured groups. Reimbursements to pharmacies are not affected by these credits.

This benefits overview insert is only one piece of your entire enrollment package. See the enrollment brochure for a list of your plan's exclusions and limitations and applicable policy form numbers.

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

Anthem Blue Cross and Blue Shield believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections of the Affordable Care Act apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Anthem Blue Cross and Blue Shield at the telephone number printed on the back of your member identification card, or contact your group benefits administrator if you do not have an identification card. For ERISA plans, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1–866–444–3272 or www.dol.gov/ebsa/healthreform. This Web site has a table summarizing which protections do and do not apply to grandfathered health plans. For nonfederal governmental plans, you may also contact the U.S. Department of Health and Human Services at www.healthcare.gov.

EXPRESS SCRIPTS®

HOME DELIVERY PHARMACY ORDER FORM

To MAIL your prescription:
1. "Patient" box must be filled out.
2. Have your Doctor write a prescription.
3. Send your new prescription along with this completed form to:
   Express Scripts Home Delivery Service
   PO Box 66785
   St. Louis MO 63166-6785

To FAX your prescription:
1. Both "Dr/Prescriber" and "Rx Form" boxes must be filled out.
2. Doctor can fax to: 1-800-600-8105
   - **Class II prescriptions cannot be faxed.**
   - Faxes will only be accepted from a doctor's office.

PATIENT

Member ID: _____

First Name: _____ Last Name: _____

Date of Birth: _____ Phone: _____

Address: _____

_____

_____

E-mail: _____

Allergies: _____

_____

Health Conditions: _____

_____

_____

Over-the-Counter Medications: _____

_____

DOCTOR/PRESCRIBER

DEA: _____

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

PATIENT OPTIONS

☐ I want non-child resistant caps, when available.
☐ I want a copy of my bottle label in large print on a separate sheet of paper.
☐ Check here for rush delivery. Once your order is received and filled, it will be shipped overnight for $21.

If you want to make a payment or update your health conditions, please visit your health plan provider's website.

2161

Rx

_____ _____ **Date:** __ __ / __ __ / __ __

First Name **Last Name**

Drug Name/Form/Strength	Qty	Directions for Use	Refills

X _____

Doctor/Prescriber Signature – Substitution Permissible

X _____

Doctor/Prescriber Signature – Dispense as Written

Stamped signatures cannot be accepted.

Ins and Outs of Coverage

Tips for understanding your coverage

Knowing the "rules of the road" for the plan you have selected can make all the difference in getting the most value from your KeyCare coverage. Here are a few tips to keep in mind when seeking services.

Services that require advance reviews

While you can see any doctor or go to any hospital you like, there may be instances in which a test or procedure your doctor wants you to have may not be covered. To help you minimize unanticipated costs from a non-covered service, we work with our in-network providers to make sure that certain services go through an advance review process first. This way, you'll know upfront whether the service is going to be covered.

An explanation on how we define emergencies

An emergency is the sudden onset of a medical condition with such severe symptoms that a person with an average knowledge of health and medicine would seek medical care immediately because there may be:

- serious risk to mental or physical health
- danger or significant impairment of body function
- significant harm to organs in the body (heart, brain, kidneys, liver, lungs, etc.)
- danger to the health of the baby in a pregnant woman

USING IN-NETWORK PROVIDERS EQUALS SAVINGS

You need a checkup. Dr. Smith is an in-network doctor and he's agreed to a fee of $200 for the service. Because he's in-network, you will simply pay whatever amount you would owe under your specific benefits plan, whether it's a specific dollar amount or a percentage of what the doctor charged, like 20% of the $200. Instead you visit Dr. Jones, and he's not in our network. Dr. Jones charges $350 for a checkup. Now you will pay not only the set fee or percentage amount required under your particular benefits plan. You may also pay an additional $150 — the difference in cost between what the in-network doctor agreed to accept as a set fee compared to what the out-of-network provider charged. Same service — totally different amount that comes out of your wallet. See why it makes sense to shop around?

Note: The estimated costs are for illustrative purposes only.

The Ins and Outs of Coverage

Knowing that you have health care coverage that meets your and your family's needs is reassuring.But part of your decision in choosing a plan also requires understanding:

- who can be enrolled
- how coverage changes are handled
- what's not covered by your plan
- how your plan works with other coverage

Who Can Be Enrolled

You can choose coverage for you alone or family coverage that includes you and any of the following family members:

- your qualified dependents*

  *as determined by the Patient Protection and Affordable Care Act

Dependent children are covered until the end of the month in which they turn 26.

Some children have mental or physical challenges that prevent them from living independently. The dependent age limit does not apply to these enrolled children as long as these challenges were present before they reached age 26.

How Coverage Changes Are Handled

Your KeyCare coverage can be renewed, cancelled or changed on two different levels. The first is on the employer level, which would impact you and everyone else covered under your employer's plan. The second level impacts your coverage only — including your covered family members — and does not apply to any others covered under your employer's plan.

The Ins and Outs of Coverage (continued)

1. On the employer level — which impacts you as well as all employees under your employer's plan — your KeyCare plan can be ...

renewed	cancelled	changed	when...
•			your employer maintains its status as an employer, remains located in our service area, meets our guidelines for employee participation and premium contribution, pays the required health care premiums and does not commit fraud or misrepresent itself.
	•		your employer makes a bad payment, voluntarily cancels coverage (30-day advance written notice required), is unable (after being given at least a 30-day notice) to meet eligibility requirements to maintain a group plan, or still does not pay the required health care premium (after being given a 31-day grace period and at least a 15-day notice).
	•		we decide to no longer offer the specific plan chosen by your employer (you'll get a 90-day advance notice) or if we decide to no longer offer any coverage in Virginia (you'll get a 180-day advance notice).
		•	your employer and you received a 30-day advance written notice that the coverage was being changed (services added to your plan or the copayment amounts decreased). Copayments can be increased or services can be decreased only when it is time for your group to renew its Lumenos coverage.

2. On an individual level — factors that apply to you and covered family members — your KeyCare plan can be...

renewed	cancelled	when...
•		you maintain your eligibility for coverage with your employer, pay your required portion of the health care premium and do not commit fraud or misrepresent yourself.
	•	you purposely give wrong information about yourself or your dependents when you enroll. Cancellation is effective immediately.
	•	you lose your eligibility for coverage, don't make required payments or make bad payments, commit fraud, are guilty of gross misbehavior, don't cooperate with coordination of benefits recoveries, let others use your ID card, use another member's ID card or file false claims with us. Your coverage will be cancelled after you receive a written notice from us.

The Ins and Outs of Coverage (continued)

Special Enrollment Periods

Typically you are only allowed to enroll in your employer's health plan during certain eligibility periods, such as when it is first offered to you as a "new hire" or during your employer's open enrollment period when employees can make changes to their benefits for an upcoming year. But there may be instances other than these situations in which you may be eligible to enroll. For example, if the first time you are offered coverage and you state in writing that you don't want to enroll yourself, your spouse or your covered dependents because you have coverage through another carrier or group health plan, you may be able to enroll your family later if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage. But, you must ask to be enrolled within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. Finally, if you or your dependents' coverage under Medicaid or the state Children's Health Insurance Program (SCHIP) is terminated as a result of a loss of eligibility, or if you or your dependents become eligible for premium assistance under a state Medicaid or SCHIP plan, a special enrollment period of 60 days will be allowed. To request special enrollment or obtain more information, contact your employer.

About Pre-Existing Conditions

(does not apply to children under the age of 19)

Have you been treated for or diagnosed as having a specific condition other than pregnancy? If you have been, did the diagnosis or treatment occur less than 6 months before the date you will begin coverage under your employer's group health plan or by the start of the waiting period required by your employer, whichever is earlier? If so, there is a 12 month period when services may* not be covered for those specific conditions — often called "pre-existing conditions." All other covered services not related to the pre-existing conditions will be available beginning on your first day as a KeyCare member. If you or a covered family member have had breast cancer and have been disease-free for five years, it is not considered a pre-existing condition, even if you have had routine follow-up visits to monitor for recurrence within the past 6 months or during your employer's required waiting period.

* Your 12-month pre-existing period can be reduced by the number of months of "creditable coverage" you had before your group health plan coverage (or employer-required waiting period) starts. Creditable coverage is earned by having had coverage under most types of group or individual: health insurance programs

- HMO plans
- health service plans
- fraternal society plans, or
- publicly-sponsored plans like Medicare, Medicaid, State Children's Health Insurance Program

(S-CHIP) or TRICARE

You should receive proof of prior coverage (called a "certificate of creditable coverage") from either the employer with whom you had the coverage or the health care company that provided it. If you go more than 63 days without health care coverage, coverage before that 63-day break will not reduce your pre-existing period. So that we may reduce the pre-existing period by the amount of time you were covered under creditable coverage, we may require you to give us a copy of any certificates of creditable coverage that you have. If you do not have a certificate, but you have creditable coverage, we will help you get one from your prior plan or issuer. Contact Member Services either by phone or by the address listed on the back of this enrollment brochure.

When You're Covered by Multiple Plans

If you're fortunate enough to be covered by more than one health plan, you may not be so thrilled about the paperwork hassles that can come with it when you're trying to figure out which plan should pay for what. Our Coordination of Benefits (COB) program helps ensure that you receive the benefits due and avoid overpayment by either carrier. Because up-to-date, accurate information is the key to our Coordination of Benefits program, you can expect to receive a COB questionnaire on an annual basis. Timely response to these questionnaires will help avoid delays in claims payment.

If you are covered by two different group health plans, one is considered primary and the other is considered secondary. The primary carrier is the first to pay a claim and provide reimbursement, typically covering the remaining allowable expenses.

The Ins and Outs of Coverage (continued)

Determining the primary versus secondary carrier

See the chart below for how determination gets made over which health plan is the primary carrier. The term "participant" is used and means the person who is signing up for coverage:

When a person is covered by 2 group plans, and	Then	Primary	Secondary
One plan does not have a COB provision	The plan without COB is	•	
	The plan with COB is		•
The person is the participant under one plan and a dependent under the other	The plan covering the person as the participant is	•	
	The plan covering the person as a dependent is		•
The person is the participant in two active group plans	The plan that has been in effect longer is	•	
	The plan that has been in effect the shorter amount of time is		•
The person is an active employee on one plan and enrolled as a COBRA participant for another plan	The plan in which the participant is an active employee is	•	
	The COBRA plan is		•
The person is covered as a dependent child under both plans	The plan of the parent whose birthday occurs earlier in the calendar year (known as the birthday rule) is	•	
	The plan of the parent whose birthday is later in the calendar year is		•
	Note: When the parents have the same birthday, the plan that has been in effect longer is	•	
The person is covered as a dependent child and coverage is stipulated in a court decree	The plan of the parent primarily responsible for health coverage under the court decree is	•	
	The plan of the other parent is		•
The person is covered as a dependent child and coverage is not stipulated in a court decree	The custodial parent's plan is	•	
	The non-custodial parent's plan is		•
The person is covered as a dependent child and the parents share joint custody	The plan of the parent whose birthday occurs earlier in the calendar year is	•	
	The plan of the parent whose birthday is later in the calendar year is		•
	Note: When the parents have the same birthday, the plan that has been in effect longer is	•	

The Ins and Outs of Coverage (continued)

How Benefits Apply When Medicare-Eligible

Some people under age 65 are eligible for Medicare in addition to any other coverage they may have. The following chart shows how payment is coordinated under various scenarios:

When a person is covered by Medicare and a group plan, and	Then	KeyCare is Primary	Medicare is Primary
Is a person who is qualified for Medicare coverage due solely to End Stage Renal Disease (ESRD-kidney failure)	During the 30-month Medicare entitlement period	•	
	Upon completion of the 30-month Medicare entitlement period		•
Is a disabled member who is allowed to maintain group enrollment as an active employee	If the group plan has more than 100 participants	•	
	If the group plan has fewer than 100 participants		•
Is the disabled spouse or dependent child of an active full-time employee	If the group plan has more than 100 participants	•	
	If the group plan has fewer than 100 participants		•
Is a person who becomes qualified for Medicare coverage due to ESRD after already being enrolled in Medicare due to disability	If Medicare had been secondary to the group plan before ESRD entitlement	•	
	If Medicare had been primary to the group plan before ESRD entitlement		•

Recovery of overpayments

If health care benefits are inadvertently overpaid, reimbursement for the overpayment will be requested. Your help in the recovery process would be appreciated. We reserve the right to recover any overpayment from:

- any person to or for whom the overpayments were made;
- any health care company; and
- any other organization.

The Ins and Outs of Coverage (continued)

What's Not Covered (Exclusions)

When it comes to your health, you're the final decision maker about what services you need to get and where you should get them from. But, in order for us to keep the cost of health care as low as possible for both you and your employer, we have to exclude certain services. The following list of services and supplies are excluded from coverage by your health plan and will not be covered in any case.

acupuncture

biofeedback therapy

over-the-counter **convenience** and hygienic items including, but not limited to, adhesive removers, cleansers, underpads, and ice bags

cosmetic surgery or procedures, including complications that result from such surgeries and/or procedures. Cosmetic surgeries and procedures are performed mainly to improve or alter a person's appearance including body piercing and tattooing. However, a cosmetic surgery or procedure does not include a surgery or procedure to correct deformity caused by disease, trauma, or a previous therapeutic process. Cosmetic surgeries and/or procedures also do not include surgeries or procedures to correct congenital abnormalities that cause functional impairment. We will not consider the patient's mental state in deciding if the surgery is cosmetic.

dental services except: medically necessary dental services resulting from an accidental injury, provided that, for an injury occurring on or after your effective date of coverage, you seek treatment within 60 days after the injury. You must submit a plan of treatment from your dentist or oral surgeon for prior approval by Anthem.

- cost of dental services and dental appliances only when required to diagnose or treat an accidental injury to the teeth
- repair of dental appliances damaged as a result of an accidental injury to the jaw, mouth or face
- dental services and appliances furnished to a newborn when required to treat medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia
- dental services to prepare the mouth for radiation therapy to treat head and neck cancer
- covered general anesthesia and hospitalization services for children under the age of 5, covered persons who are severely disabled, and covered persons who have a medical condition that requires admission to a hospital or outpatient surgery facility. These services are provided when it is determined by a licensed dentist, in consultation with the covered persons' treating physician that such services are required to effectively and safely provide dental care.

donor searches for organ and tissue transplants, including compatibility testing of potential donors who are not immediate, blood-related family members (parent, child, sibling)

The Ins and Outs of Coverage (continued)

EXPERIMENTAL ... OR NOT?

Many of the Anthem medical directors and staff actively participate in a number of national health care committees that review and recommend new experimental or investigative treatments for coverage. To be approved for coverage, the service or product must have:

- **regulatory approval from the Food and Drug Administration;**
- **been put through extensive research study to find all the benefits and possible harms of the technology;**
- **benefits that are far better than any potential risks;**
- **at least the same or better effectiveness as any similar service or procedure already available; and**
- **been tested enough so that we can be certain it will result in positive results when used in real cases.**

experimental/investigative procedures, as well as services related to or complications from such procedures except for clinical trial costs for cancer as described by the National Cancer Institute. This will not prevent a member from being able to appeal Anthem's decision that a service is not experimental/investigative.

family planning

- any services or supplies provided to a person not covered that is in connection with a surrogate pregnancy, including but not limited to, the bearing of a child by another woman for an infertile couple
- services to reverse voluntarily induced sterility
- services for artificial insemination or in vitro fertilization or any other types of artificial or surgical means of conception including any drugs administered in connection with these procedures
- drugs used to treat infertility

services for palliative or cosmetic **foot** care

- flat foot conditions
- support devices, arch supports, foot inserts, orthopedic and corrective shoes that are not part of a leg brace and fittings, castings and other services related to devices of the feet
- foot orthotics
- subluxations of the foot
- corns
- bunions (except capsular or bone surgery)
- calluses
- care of toenails
- fallen arches
- weak feet
- chronic foot strain
- symptomatic complaints of the feet

health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a physician. This exclusion also applies to health spas.

hearing care except in relation to preventive care screenings (Implantable or removable hearing aids, except for cochlear implants, are not covered.)

home care services

These services are not covered by your KeyCare plan.

- homemaker services
- maintenance therapy
- food and home delivered meals
- custodial care and services

hospital services

- guest meals, telephones, televisions, and any other convenience items received as part of your inpatient stay
- care by interns, residents, house physicians, or other facility employees that are billed separately from the facility
- a private room unless it is medically necessary

maternity benefits for your unmarried dependent children

medical equipment, appliances and devices, and medical supplies that have both a nontherapeutic and therapeutic use:

- exercise equipment
- air conditioners, dehumidifiers, humidifiers, and purifiers
- hypoallergenic bed linens
- whirlpool baths
- handrails, ramps, elevators, and stair glides
- telephones
- adjustments made to a vehicle
- foot orthotics
- changes made to a home or place of business
- repair or replacement of equipment you lose or damage through neglect

medical equipment (durable) that is not appropriate for use in the home

services or supplies deemed **not medically necessary** as determined by Anthem at its sole discretion. This will not prevent a member from being able to appeal Anthem's decision that a service is not medically necessary.

The following exceptions qualify for coverage.

For inpatients:

1. services rendered by professional providers who do not control whether you are treated on an inpatient basis, such as pathologists, radiologists, anesthesiologists, and consulting physicians or related outpatient services or as part of your outpatient services will not be denied under this exclusion in spite of the medical necessity denial of the overall services
2. services rendered by your attending provider other than inpatient evaluation and management services. Inpatient evaluation and management services include routine

visits by your attending provider to review patient status, test results, and patient medical records and do not include surgical, diagnostic, or therapeutic services.

For outpatients:

services of pathologists, radiologists and anesthesiologists rendering services in an (i) outpatient hospital setting, (ii) emergency room, or (iii) ambulatory surgery setting. This exception does not apply if and when pathologist, radiologist or anesthesiologist assumes the role of attending physician.

mental health and substance abuse

- inpatient stays for environmental changes
- cognitive rehabilitation therapy
- educational therapy
- vocational and recreational activities
- coma stimulation therapy
- services for sexual deviation and dysfunction
- treatment of social maladjustment without signs of a psychiatric disorder
- remedial or special education services
- inpatient mental health treatments that meet the following criteria:
  - more than 2 hours of psychotherapy during a 24-hour period in addition to the psychotherapy being provided pursuant to the inpatient treatment program of the hospita
  - group psychotherapy when there are more than 8 patients with a single therapist
  - group psychotherapy when there are more than 12 patients with two therapists
  - more than 12 convulsive therapy treatments during a single admission
  - psychotherapy provided on the same day of convulsive therapy

nutrition counseling and related services, except when provided as part of diabetes education or when received as part of a covered wellness services visit or screening

nutritional and/or dietary supplements, except as specifically listed in this enrollment brochure or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist.

obesity services and supplies related to weight loss or dietary control, including complications that directly result from such surgeries and/or procedures. This includes weight reduction therapies/activities, even if there is a related medical problem. Notwithstanding provisions of other exclusions involving cosmetic surgery to the contrary, services rendered to improve appearance (such as abdominoplasties, panniculectomies, and lipectomies), are not covered services even though the services may be required to correct deformity after a previous therapeutic process involving gastric bypass surgery.

organ or tissue transplants, including complications caused by them, except when they are considered medically necessary, have received pre-authorization, and are not considered experimental/investigative. Autologous bone marrow transplants for breast cancer are covered only when the procedure is performed in accordance with protocols approved by the institutional review board of any United States medical teaching college. These include, but are not limited to, National Cancer Institute protocols that have been favorably reviewed and used by hematologists or oncologists who are experienced in high dose chemotherapy and autologous bone marrow transplants or stem cell transplants. This procedure is covered despite the exclusion in the plan of experimental/investigative services.

paternity testing

prescription drug benefits

- over-the-counter drugs
- any per unit, per month quantity over the plan's limit
- drugs used mainly for cosmetic purposes
- drugs that are experimental, investigational, or not approved by the FDA
- cost of medicine that exceeds the allowable charge for that prescription
- drugs for weight loss
- stop smoking aids
- therapeutic devices or appliances
- injectable prescription drugs that are supplied by a provider other than a pharmacy
- charges to inject or administer drugs
- drugs not dispensed by a licensed pharmacy
- drugs not prescribed by a licensed provider
- any refill dispensed after one year from the date of the original prescription order
- medicine covered by workers' compensation, Occupational Disease Law, state or government agencies
- medicine furnished by any other drug or medical service
- medications used to treat sexual dysfunction (only applicable for groups who have selected a Generic Premium Options drug plan)

private duty nurses in the inpatient setting

rest cures, custodial, residential or domiciliary care and services. Whether care is considered residential will be determined based on factors such as whether you receive active 24-hour skilled professional nursing care, daily physician visits, daily assessments, and structured therapeutic service.

care from **residential treatment centers** or other non-skilled inpatient settings, except to the extent such setting qualified as a substance abuse treatment facility licensed to provide a continuous, structured, 24-hour-a-day program of drug or alcohol treatment and rehabilitation including 24-hour-a-day nursing care

services or supplies

- ordered by a doctor whose services are not covered under your health plan
- are of any type given along with the services of an attending provider whose services are not covered
- not listed as covered under your health plan
- not prescribed, performed, or directed by a provider licensed to do so
- received before the effective date or after a covered person's coverage ends
- telephone consultations, charges for not keeping appointments, or charges for completing claim forms

services or supplies

- for travel, whether or not recommended by a physician
- given by a member of the covered person's immediate family
- provided under federal, state, or local laws and regulations including Medicare and other services available through the Social Security Act of 1965, as amended, except as provided by the Age Discrimination Act. This exclusion applies whether or not you waive your rights under these laws and regulations. It does not apply to laws that make the government program the secondary payor after benefits under this policy have been paid. Anthem will pay for covered services when these program benefits have been exhausted.
- provided under a U.S. government program or a program for which the federal or state government pays all or part of the cost. This exclusion does not apply to health benefits plans for civilian employees or retired civilian employees of the federal or state government
- received from an employer mutual association, trust, or a labor union's dental or medical department
- for diseases contracted or injuries caused because of war, declared or undeclared, voluntary participation in civil disobedience, or other such activities

services for which a charge is not usually made including those services for which you would not have been charged if you did not have health care coverage

services or benefits for:

- amounts above the allowable charge for a service
- self-administered services or self care
- self-help training
- biofeedback, neurofeedback, and related diagnostic tests

These services are not covered by your KeyCare plan

services or supplies primarily for educational, vocational, or self-management/training purposes, except as otherwise specified, except when received as part of a covered wellness services visit or screening

sexual dysfunction surgery or sex transformation services, including medical and mental health services

skilled nursing facility stays

- treatment of psychiatric conditions and senile deterioration
- facility services during a temporary leave of absence from the facility
- a private room unless it is medically necessary

smoking cessation programs not affiliated with us

spinal manipulations or other manual medical interventions for an illness or injury other than musculoskeletal conditions

telemedicine

- non-interactive telemedicine services, including audio only telephone, electronic mail message or facsimile transmission

therapies

- physical therapy, occupational therapy, or speech therapy to maintain or preserve current functions if there is no chance of improvement or reversal except for children under age 3 who qualify for early intervention services
- group speech therapy
- group or individual exercise classes or personal training sessions
- recreation therapy including, but not limited to, sleep, dance, arts, crafts, aquatic, gambling, and nature therapy

vision services

- vision services or supplies unless needed due to eye surgery and accidental injury
- routine vision care and materials
- services for radial keratotomy and other surgical procedures to correct refractive defects such as nearsightedness, farsightedness and/or astigmatism. This type of surgery includes keratoplasty and Lasik procedure;
- services for vision training and orthoptics
- tests associated with the fitting of contact lenses unless the contact lenses are needed due to eye surgery or to treat accidental injury
- sunglasses or safety glasses and accompanying frames of any type
- any non-prescription lenses, eyeglasses or contacts, or Plano lenses or lenses that have no refractive power
- any lost or broken lenses or frames

These services are not covered by your KeyCare plan

- any blended lenses (no line), oversize lenses, progressive multifocallenses, photchromatic lenses, tinted lenses, coated lenses, cosmetic lenses or processes, or UV-protected lenses
- services needed for employment or given by a medical department, clinic, or similar service provided or maintained by the employer or any government entityany other vision services not specifically listed as covered
- any other vision services not specifically listed as covered

weight loss programs whether or not they are pursued under medical or physician supervision, unless specifically listed as covered. This exclusion includes, but is not limited to commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

services or supplies if they are for **work-related** injuries or diseases when the employer must provide benefits by federal, state, or local law or when that person has been paid by the employer. This exclusion applies even if you waive your right to payment under these laws and regulations or fail to comply with your employer's procedures to receive the benefits. It also applies whether or not the covered person reaches a settlement with his or her employer or the employer's insurer or self insurance association because of the injury or disease.

Additional Benefits

Blue View Vision℠

Vision care is not just for eyeglass wearers. Routine eye visits are important for everyone in preventing eyesight damage. In fact, eye exams can also help detect other health problems. Blue View Vision exists so you can get the vision care you need without feeling like you're busting your budget.

Advantages of Anthem Blue View Vision:

- **You have access to eye doctors close to you.** Blue View Vision has 44,000 eye doctors and locations in its network. If you don't already have a favorite, you can quickly find one. Plus, many retail locations, like LensCrafters®, Target® Optical, Sears Optical and Pearle Vision®, are covered by the plan. Finding a Blue View Vision network provider is easy — simply visit anthem.com.
- **You can get an eye exam every year.** Not every other year like other plans. Blue View Vision helps pay for eye exams annually.
- **Not many plans are this simple.** Just schedule an appointment with a network provider and present your member ID card when you arrive. The doctor's office staff will take care of the rest. And in most instances, you just need to pay a low copayment.
- **You save even more with additional discounts.** Want a frame that costs more than your plan allows? You save 20 percent off the balance. Want spare glasses, contact lenses or prescription sunglasses? Save 15 to 40 percent. Your additional discounts are unlimited — even after your vision care benefits have exhausted.
- **You've always got someone to help.** If you're seeing your eye doctor at night or on weekends, that's when we should be available to help you. So we're open Monday through Saturday, 8 a.m. to 11 p.m. Eastern time *and* Sunday 11 a.m. to 8 p.m. Eastern time. Or you can reach the interactive voice response system most any time of the day.

What happens if you use an eye professional not in the network?

You're still covered. You'll be asked to pay the full cost for services at the time of your appointment. When you mail in your receipt and other paperwork to Anthem, you'll get paid back for what the plan covers. To save the most money and have less hassle, try to use an eye doctor or retail location in the network.

This is a brief overview of your plan's features. Your summary of benefits contains the details. See your benefits manager if you need a copy. Thank you for considering Anthem Blue Cross and Blue Shield.

WELCOME TO BLUE VIEW VISION!
Good news—your vision plan is flexible and easy to use. This benefit summary outlines the basic components of your plan, including quick answers about what's covered, your discounts, and much more!

Blue View Vision℠

Your Blue View Vision network
Blue View Vision offers you one of the largest vision care networks in the industry, with a wide selection of experienced ophthalmologists, optometrists, and opticians. Blue View Vision's network also includes convenient retail locations, many with evening and weekend hours, including LensCrafters®, Target Optical®, JCPenney® Optical, Sears Optical℠, and Pearle Vision® locations. Best of all – when you receive care from a Blue View Vision participating provider, you receive the greatest benefits and money-saving discounts.

Out-of-network services
Did we mention we're flexible? You can choose to receive care outside of the Blue View Vision network. You simply get an allowance toward the eye exam and you pay the rest. (Network benefits and discounts will not apply.) Just pay in full at the time of service and then file a claim for reimbursement.

YOUR BLUE VIEW VISION PLAN AT-A-GLANCE

VISION CARE SERVICES	IN-NETWORK	OUT-OF-NETWORK
Annual routine eye exam *(once every calendar year)*	$15 copayment	$30 allowance

DISCOUNTS
Savings on eyewear and accessories
When you visit a participating Blue View Vision eye care professional or vision center, you'll pay the discount price for as many pairs of eyeglasses and/or supplies of conventional (non-disposable) contact lenses as you would like. Take advantage of these savings –it means more money in your pocket!

BLUE VIEW VISION ADDITIONAL SAVINGS	MEMBER SAVINGS
Eye Glass Frame*	35% discount off retail*
Contact Lenses** Conventional (non-disposable)	15% off retail price
Standard Plastic Lenses* Single Vision Bifocal Trifocal	 You Pay: $50 You Pay: $70 You Pay: $105
Eyeglass Lens Options/Upgrades* – For those who like to add an extra touch to their eyewear! UV Coating Tint (Solid and Gradient) Standard Scratch-Resistance Standard Polycarbonate Standard Progressive (Add-on to bifocal) Standard Anti-Reflective Coating	 You Pay: $15 You Pay: $15 You Pay: $15 You Pay: $40 You Pay: $65 You Pay: $45
Other Add-ons and Services Includes some non-prescription sunglasses, lens cleaning supplies, contact lens solutions and eyeglass cases, etc.	20% off retail price

Discounts are subject to change without notice.

** If frames, lenses or lens options are purchased separately, members get a 20% discount instead.*
***Discount does not apply to fitting fees or services.*

WELCOME TO BLUE VIEW VISION!
Good news—your vision plan is flexible and easy to use. This benefit summary outlines the basic components of your plan, including quick answers about what's covered, your discounts, and much more!

And – there's more! You also get access to discounts on other vision services through SpecialOffers. Visit anthem.com/specialoffers to learn more about these valuable savings.

Laser vision correction surgery
Glasses or contacts may not be the answer for every person. That's why we offer further savings with discounts on refractive surgery. Pay a discounted amount per eye for LASIK or PRK Laser Vision correction. For more information go to SpecialOffers at anthem.com/specialoffers and select Vision Care.

USING YOUR BLUE VIEW VISION PLAN
The Blue View Vision network is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care physician from your medical network. Your out-of-pocket expenses related to the vision benefits do not count toward your annual out-of-pocket limit and are never waived, even if your annual out-of-pocket limit is reached.

360° Health and More

360° Health®

You can learn more about these programs online. To get started, go to anthem.com, click on "360° Health", then select the "Improve Your Health" tab.

You can also call Anthem Customer Service. The number is on the back of your member ID card.

Anthem's 360° Health can be the most valuable part of your health plan. It surrounds you with programs and services that help you get healthy, stay healthy and live better.

It's a basic idea: the more you know, the healthier you can be. Instead of waiting for health problems (and their costs) to crop up, 360° Health can help you prevent them or keep them from getting worse. Best of all, 360° Health is built into your plan at no extra cost. It's just that important.

Whatever stage of health you're in, at least one 360° Health program is meant for you.

Not all programs are available in all areas. Talk to your employer about which of these and other 360° Health programs may be part of your plan.

MyHealth@Anthem®

Finding health information online can be like using a dictionary that's not alphabetized. This personalized site makes it easy to find the information that matters to you, manage your health, and stay motivated. Whether you're taking a health assessment, tracking your blood pressure or browsing its Diabetes Condition Center, you're on the path to better health. Log on today, look around and see which one of these valuable features can help you:

- Get a clear picture of your health with a quick health risk assessment.
- Make the most of your next doctor visit by filling out a pre-visit questionnaire.
- Take advantage of focused features like a pregnancy planner, child health manager, and depression and anxiety screening tools.
- Get ideas for living a healthier life with daily healthy tips and lifestyle centers.
- Join our online communities, which cover over 30 health and wellness topics.
- Learn all about a condition or diagnosis anytime with our in-depth Condition Centers.

MyHealth Assessment

If you graded your health today, what score would you get? Pinpoint your risks and what to do about them with this ultra-fast questionnaire and detailed report. MyHealth Assessment is a secure and confidential health analysis that looks at over 180 factors related to family history, lifestyle choices and your readiness to change. It pays special attention to 11 serious conditions, including heart disease, diabetes, stroke, chronic obstructive pulmonary disease (COPD), and various cancers. Essentially, MyHealth Assessment looks at what you're doing now, then considers what you could be doing differently. Your answers to a broad range of simple questions results in an in-depth report personalized just for you — complete with risks, results and action steps. With our exclusive interactive scoring, it's easy to try "what if" scenarios to test the impact that specific lifestyle changes could have on your health. Perfect conversation pieces when talking to your doctor about your risk factors.

Special Offers

Saving money is good. Saving money on things that are good for you — that's even better. With our special offers, you get members-only discounts on healthy lifestyle products and services. You can save on fitness gear, health and wellness books, maternity and baby items, weight loss

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360° Health (continued)

programs, eyeglasses, health and beauty products, gym memberships — too many discounts to list them all here.

Health Care Advisor

When you have a treatment decision to make, you need the facts. You'll find a lot of them inside Health Care Advisor, your online source of objective research. Here you can learn more about medical conditions, procedures and treatment options. You'll also find performance data about specific hospitals and guidance on complication rates, treatment options and questions you should ask before an upcoming procedure. In the end, Health Care Advisor can help you decide which hospitals or facilities are best suited for your needs and your procedure. It's interactive. It's online. It's all about making informed choices.

MyHealth Record

Before making any decisions about your care, your doctor looks at your chart. Now you can do the same. Store all of your health records — easily and securely — in one convenient spot with MyHealth Record. Keep track of medical appointments, health history, screenings, claims, medications and more. Your records will be available to help guide your care wherever you are. You can use MyHealth Record to:

- Consolidate your health history in one secure location.
- Track doctor visits, vaccinations and other wellness services — a great help if you see multiple doctors.
- Print out and share your health summary with your doctors.
- Share information with your pharmacist, who can view your current medications and medical history to check for possible issues.
- Carry a medical summary card — complete with blood type, allergies and medical conditions — in case of emergency.

24/7 NurseLine

Health questions and concerns don't keep regular business hours. They crop up at 3 a.m. with a sick child or on the road with a strange food reaction. When you need answers right away, you have direct, round-the-clock access to a Nurse Coach with an average of 19 years of experience. Maybe you have general health questions — the nurse can offer guidance and information. Maybe you have a critical health concern — the nurse can help you decide whether to handle it at home, with a doctor appointment, or in the emergency room. The 24/7 NurseLine also features bilingual nurses and translators if English isn't your first language. And if you're more of the do-it-yourself type, you can select the AudioHealth Library option to hear recordings on more than 300 common health topics. Have a question about your health? Answers are just one toll-free call away.

For more information, please call **800-337-4770**.

NurseLine doesn't replace your doctor. If your situation is life threatening or you are critically ill, go to the nearest emergency room or call 911.

360° Health (continued)

Behavioral Health Services

Anxiety. Depression. Substance abuse. Behavioral health issues can impair a person's life as much as any physical illness. To help you cope with these common health issues, we offer a wide network of psychiatrists, psychologists, social workers and substance abuse services. And you don't need a referral to see one of them. Simply call our help line to make sure you'll be covered. The Behavioral Health help line is confidential and open 24/7. Use it when you need to:

- Talk to a clinical care manager about emergencies or urgent problems.
- Ask for help with choosing a behavioral health service, provider or hospital.
- Get coverage information, specialist referrals or any pre-approvals that your plan calls for.

Future Moms

Pregnancy is a time of hopes, dreams, questions...and also doubts. For a safe delivery and a healthy child, being well-informed can help you make good choices. Future Moms is an award-winning voluntary program with the answers and support you need. A team of Nurse Coaches is available 24/7 through our special toll free number. These specially trained obstetric nurses can answer your questions about pregnancy, labor, nursing, postpartum depression and other maternity concerns. They'll also evaluate your risk for preterm delivery and send educational materials for every stage of pregnancy. As soon as you know you're expecting, just pick up the phone and call Future Moms. One of our nurses will send everything you need to get started. So you know what to expect every step of the way.

For more information, please call **800-828-5891**.

MyHealth Advantage

Many health issues can be avoided if they're detected early. Unfortunately, as days get busy and health care becomes more complex, this can be harder to do. Thankfully, MyHealth Advantage is busy working behind the scenes. This confidential program analyzes your health claims and lab results to try to catch potential issues before they cause problems or cost you money. The program tries to spot possible gaps in care, medication safety issues and cost savings opportunities. If something comes up, we send you a message called a MyHealth Note. This is a personalized alert with specific action steps and personal health guidance. If a critical issue is identified, your doctor may get one, too. Because it's comforting to know that someone is looking out for you.

ConditionCare

Chronic diseases need continuous attention. Thankfully, you're not alone when facing difficult cases of asthma, diabetes, chronic obstructive pulmonary disease, coronary artery disease or heart failure. ConditionCare helps you take control once again. The Nurse Coaches with ConditionCare give you the information and support you need to manage your symptoms and get more out of life. How? By addressing the whole person, not just the disease. Our nurses will talk with you about your health goals, your current lifestyle and the advice you've received from your doctor. They'll make sure you understand your condition and what it means to your daily life. Then your dedicated Nurse Coach will create a self-management plan just for you. And once the plan

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360° Health (continued)

is in place, we link you with a team of health professionals who can help you fit the plan into your life — dietitians, health educators, pharmacists and social workers. Every one of them dedicated to helping you manage your condition.

For more information, please call **800-445-7922**.

Comprehensive Medical Management

You have someone in your corner when facing a difficult health crisis. With Comprehensive Medical Management, you'll get expert one-on-one help during critical times. Your medical manager will make sure that you're getting the most from your benefits and that the care and services you receive are appropriate, necessary, high-quality and safe. It's like having your own personal health advocate.

To get started: No need to do anything. A care manager will contact you if you might benefit from these services.

ComplexCare

Managing your own health care needs can be tough. That's especially true when you're dealing with several complicated conditions. As your care grows more complex, you might be at risk for even bigger problems in the future. Our ComplexCare Nurse Coaches specialize in coordinating and planning even the most challenging cases for those who need help the most. Your dedicated Nurse Coach will work closely with you and your doctors to create an individualized care plan. And most importantly, your Nurse Coach will coordinate care between all of your doctors and services to make sure everyone is on the same page. You'll also receive:

- One-on-one attention, goal planning, health and lifestyle coaching.
- Skills for managing your condition and keeping up with medications.
- Answers to your questions about specific treatments.
- Help in making informed decisions about your health care.

To get started: No need to do anything. A care manager will contact you if you might benefit from these services.

Your connection to healthy living starts at anthem.com

You want to stay healthy and make the most of your benefits for both you and your family. That's why we offer you resources that encourage you to take control of your health plan. Anthem.com provides access to a secure, personalized website and interactive health tools that are built around you, your benefits and your health.

A personal path to better health

Good health means different things to different people. From ramping up your workout to snuffing out cigarettes, anthem.com can help you improve your health outlook. Find the information, tips and tools you need to help you take control of your health — and make smart health care decisions.

Plot your course

Our health assessment asks you to take an honest look at your health, get acquainted with your personal risk factors, read a doctor's summary and get specific action steps you can take to help reduce your risks — and improve your health.

Enlist professional help

Searching for a Spanish-speaking, female dermatologist? You can find her. Whether you want to search by name, gender, ZIP code or languages spoken, our online directory helps you find the doctor, hospital or other health care professional you're looking for. Need directions? No problem. We can help you locate the doctor's office or even a hospital or pharmacy if you need one.

Create a new record

The health record lets you access and manage your records online — privately and securely. You can also view your medical claims and find your records in one convenient, well-organized place. The health record helps keep track of medical appointments so you know when you are due for a health screening. Many members rely on the health record to help share health information with caregivers away from home or during emergencies.

Save money

Access discounts up to 50% on health clubs, teeth whitening products, frames and lenses, maternity must-haves, alternative therapy and a variety of health-related products, from independent companies and vendors. Find exactly what you need to help maintain a healthy lifestyle and save money at the same time.

Your connection to healthy living starts at anthem.com (continued)

Feel confident about your decisions

Your doctor says you need to have a procedure done in the hospital — and you have lots of questions. Our tools allow you to stay informed and help you to make smarter health choices by giving you the ability to research conditions and procedures, compare hospitals, estimate treatment costs, check for potential drug interactions and more.

Find information and support along the way

Stressed out? Overweight? Cholesterol too high? Our health channels point you to the information that matters to you. Find the support that can help you make important changes and stay on top of chronic concerns. Not sure where to begin? Just check the recommendations at the end of your health assessment — they're based on the information you provide.

Make the most of your Anthem benefits. Check us out online at anthem.com.

Note: Any member over 18 may create a unique user ID and password. Members may also restrict viewing of their information by clicking the Restricted View option.

Decision support tools help you make smart choices

If you only do one thing today... make it registering on anthem.com.

Knowledge is power. The more you know, the easier it is to decide what to do. Once you're registered on anthem.com, you'll have access to a world of health coverage and benefit information. Whether you're healthy or have medical problems, you'll find tools, resources and support to help you make smart decisions.

Tap into everything you need to manage your benefits and your health.

Once you're registered, you have access to all the following.

- **MyAnthem™ —** your personalized benefits site. Most questions you have can be answered here.

  Find a doctor or facility

  View coverage and benefit information

  Review current and past claims

  Request new ID cards

  Check dependent eligibility information

  Ask questions about your benefits

  Use the secure message center to receive news, drug alerts and tips based on your specific interests

- **Coverage Advisor™ —** understand what health care services you might need and estimate the costs for those services.
- **Treatment Cost Advisor™ —** view estimated costs for specific services, tests, doctor visits and medications.
- **Anthem Care Comparison —** see quality and price ranges for common medical fees and information on inpatient and outpatient services and office visits.
- **MyHealth Record —** build a safe, online health profile so all your important medical information is in one place, available to you at anytime. You start by adding your own information. Then your record is automatically updated as you use health services and your claims are paid. Use MyHealth Record to:

  Consolidate your health history in one secure location

  Track doctor visits, vaccinations and other wellness services — a great help if you see multiple doctors

  Print out and share your health summary with your physicians — it could identify an important detail or quickly update a new doctor on your medical history

  Help avoid potentially dangerous drug interactions, medicines you're allergic to, or duplicative tests and procedures

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Decision support tools help you make smart choices (continued)

- **MyHealth Assessment —** helps you pinpoint your personal health risks through a secure online health analysis. Taking it a step further, you'll get a personalized report with action steps designed to help you manage, reduce or eliminate those risks. Plus, MyHealth Assessment automatically populates MyHealth Record. You can easily follow your progress as you make recommended lifestyle changes.
- **Staying Healthy Reminders —** sign up for reminder phone calls or postcards alerting you when it's time for a checkup, immunizations or screenings.
- **SpecialOffers@Anthem —** see all the discounts available to you for healthy living products and services, like fitness club memberships and LASIK.[1]
- **MyHealth@Anthem® —** find tools and information to help you better evaluate and manage your health.

Manage chronic and acute conditions through Condition Centers®

Find prevention information

Monitor a pregnancy and the health of children ages six and younger

Search a medical dictionary with more than 57,000 entries

Access the online communities with over 30 health and wellness topics

Registering is easy.

All you need is your ID card, the Internet and five minutes.

1. Go to anthem.com
2. From the home page:

   Click "Member"

   Select your state from the center box

   Select " Now" from the left side
3. Click "Continue" on the Member Service Functions page
4. Click "I Agree" on the Anthem Member Services Online Access Agreement page
5. Fill in the required fields
6. Click "Continue"

By the way... It's for your eyes only!

You can rest easy knowing your personal health information is safeguarded with our strict privacy and security standards. You can view these standards while online at anthem.com.

[1]Vendors and offers are subject to change without prior notice. Anthem does not endorse and is not responsible for the products, services or information provided by the Special Offers vendors. Arrangements and discounts were negotiated between each vendor and Anthem for the benefit of our members.

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Health care reform and your plan

What's changing and when?

You've probably heard a lot of people talk about health care reform lately. But you may have questions about what it all means for you and your family – questions that even your news junkie neighbor can't answer.

JOIN IN.

To share your thoughts and ask questions about health care reform, visit healthychat.com.

Here's a quick summary of how the new law may affect your group health plan within the next year. Keep in mind that other employers' plans may have different rules. If you have questions about your specific benefits, call the customer service number on your member ID card or contact your group benefits administrator for a number to call.

When you enroll:

You'll have a chance to add young adult dependents to your plan

The federal health care reform law allows children to stay on their parent's or guardian's health plan until their 26th birthday. In some states, dependents can stay on the plan even longer. To be eligible for this coverage, children do not need to be financially dependent on you for support, claimed as dependents on your tax return, residents of your household, enrolled as students or unmarried. If you have dependents younger than 26 who aren't on your plan now, you can add them to your plan during your next open enrollment. If your plan already covers dependents up to age 26, you don't have to do anything. They'll stay on your plan automatically.

After your plan's effective date:

Kids under 19 can get coverage even if they have health conditions

The law says group health plans and insurers can't have pre-existing condition exclusions for children under the age of 19. Healthcare.gov, a website run by the federal government, defines a pre-existing condition as "a condition, disability or illness (either physical or mental) that you have before you enrolled in a health plan." Very few group health plans deny coverage altogether because of pre-existing conditions. However, some plans still have waiting periods for members who have pre-existing conditions. A waiting period means certain benefits aren't available right away.

You may have more flexibility in choosing doctors

This part of the law applies to you only if your plan requires you to select a primary care provider (PCP) and get referrals from your PCP to see a specialist. If you have this type of plan, you'll have the right to choose any primary care provider as your PCP, as long as the provider is in our network and will accept you or your family members. If your plan covers children, you may choose a pediatrician as their primary care provider. Also, you don't need prior approval from the plan or a referral from your primary care provider to get obstetrical or gynecological care from an in-network OB-GYN.

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Health care reform and your plan (continued)

Your plan's dollar limits may change

In the past, plans could have a "lifetime maximum" – a dollar limit on what the plan will pay for health care services over your lifetime. If your plan had a lifetime maximum, it's gone now. However, you should know that other limits may still apply. For example, you may have limits on certain services that aren't considered "essential health benefits." Also, you may have limits on how many times you can use a benefit during the year.

WHAT'S NEXT?

We don't want to overwhelm you, so this list only includes changes that may affect you within the next year. Other changes will take place through 2018, such as:

- **Guaranteed coverage for people of all ages – not just children – regardless of their health**
- **Health insurance exchanges where people who buy individual coverage and people who work for small businesses can shop for a plan**
- **Information on your W-2 tax statement about how much your employer paid for your health plan**
- **Changes to make health care more affordable for people who have Medicare**

If you want to know more, you can get the latest information about health care reform at healthychat.com.

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Important legal information you should take time to read

Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act explains your rights for treatment under the health plans if you need a mastectomy. Plain and simple... we're here for you.

If you ever need a benefit-covered mastectomy, we hope it will give you some peace of mind to know that your Anthem Blue Cross and Blue Shield benefits comply with the Women's Health and Cancer Rights Act of 1998, which provides for:

- Reconstruction of the breast(s) that underwent a covered mastectomy.
- Surgery and reconstruction of the other breast to restore a symmetrical appearance.
- Prostheses and coverage for physical complications related to all stages of a covered mastectomy, including lymphedema.
- All applicable benefit provisions will apply, including existing deductibles, copayments and/or co-insurance.

HIPAA NOTICE OF PRIVACY PRACTICES

The HIPAA Notice of Privacy Practices explains the rules around how we handle your private information under HIPAA laws. Plain and simple... we don't share your information unless it's needed to manage your benefits or you give us the OK to do it.

We keep the health and financial information of our current and former members private as required by law, accreditation standards, and our rules. This notice explains your rights. It also explains our legal duties and privacy practices. We are required by federal law to give you this notice.

Your Protected Health Information

We may collect, use, and share your Protected Health Information (PHI) for the following reasons and others as allowed or required by law, including the HIPAA Privacy rule:

For Payment: We use and share PHI to manage your account or benefits; or to pay claims for health care you get through your plan. For example, we keep information about your premium and deductible payments. We may give information to a doctor's office to confirm your benefits.

For Health Care Operations: We use and share PHI for our health care operations. For example, we may use PHI to review the quality of care and services you get. We may also use PHI to provide you with case management or care coordination services for conditions like asthma, diabetes, or traumatic injury.

For Treatment Activities: We do not provide treatment. This is the role of a health care provider such as your doctor or a hospital. But, we may share PHI with your health care provider so that the provider may treat you.

To You: We must give you access to your own PHI. We may also contact you to let you know about treatment options or other health-related benefits and services. When you or your

dependents reach a certain age, we may tell you about other products or programs for which you may be eligible. This may include individual coverage. We may also send you reminders about routine medical checkups and tests.

To Others: You may tell us in writing that it is OK for us to give your PHI to someone else for any reason. Also, if you are present, and tell us it is OK, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are not present, if it is an emergency, or you are not able to tell us it is OK, we may give your PHI to a family member, friend or other person if sharing your PHI is in your best interest.

As Allowed or Required by Law: We may also share your PHI, as allowed by federal law, for many types of activities. PHI can be shared for health oversight activities. It can also be shared for judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and to coroners, funeral directors or medical examiners (about decedents). PHI can also be shared for certain reasons with organ donation groups, for research, and to avoid a serious threat to health or safety. It can be shared for special government functions, for workers' compensation, to respond to requests from the U.S. Department of Health and Human Services and to alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or other crimes. PHI can also be shared as required by law.

If you are enrolled with us through an employer sponsored group health plan, we may share PHI with your group health plan. We and/or your group health plan may share PHI with the sponsor of the plan. Plan sponsors that receive PHI are required by law to have controls in place to keep it from being used for reasons that are not proper.

Authorization: We will get an OK from you in writing before we use or share your PHI for any other purpose not stated in this notice. You may take away this OK at any time, in writing. We will then stop using your PHI for that purpose. But, if we have already used or shared your PHI based on your OK, we cannot undo any actions we took before you told us to stop.

Genetic Information: If we use or disclose PHI for underwriting purposes, we are prohibited from using or disclosing PHI that is genetic information of an individual for such purposes.

Your Rights

Under federal law, you have the right to:

- Send us a written request to see or get a copy of certain PHI or ask that we correct your PHI that you believe is missing or incorrect. If someone else (such as your doctor) gave us the PHI, we will let you know so you can ask them to correct it.
- Send us a written request to ask us not to use your PHI for treatment, payment or health care operations activities. We are not required to agree to these requests.
- Give us a verbal or written request to ask us to send your PHI using other means that are reasonable. Also let us know if you want us to send your PHI to an address other than your home if sending it to your home could place you in danger.
- Send us a written request to ask us for a list of certain disclosures of your PHI.

Important legal information you should take time to read (continued)

Call Customer Service at the phone number printed on your identification (ID) card to use any of these rights. They can give you the address to send the request. They can also give you any forms we have that may help you with this process.

How we protect information

We are dedicated to protecting your PHI. We set up a number of policies and practices to help make sure your PHI is kept secure.

We keep your oral, written, and electronic PHI safe using physical, electronic, and procedural means. These safeguards follow federal and state laws. Some of the ways we keep your PHI safe include offices that are kept secure, computers that need passwords, and locked storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. The policies limit access to PHI to only those employees who need the data to do their job. Employees are also required to wear ID badges to help keep people, who do not belong, out of areas where sensitive data is kept. Also, where required by law, our affiliates and non-affiliates must protect the privacy of data we share in the normal course of business. They are not allowed to give PHI to others without your written OK, except as allowed by law.

Potential Impact of Other Applicable Laws

HIPAA (the federal privacy law) generally does not preempt, or override other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to provide you with more privacy protections, then we must also follow that law in addition to HIPAA.

Complaints

If you think we have not protected your privacy, you can file a complaint with us. You may also file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services. We will not take action against you for filing a complaint.

Contact Information

Please call Customer Service at the phone number printed on your ID card. They can help you apply your rights, file a complaint, or talk with you about privacy issues.

Copies and Changes

You have the right to get a new copy of this notice at any time. Even if you have agreed to get this notice by electronic means, you still have the right to a paper copy. We reserve the right to change this notice. A revised notice will apply to PHI we already have about you as well as any PHI we may get in the future. We are required by law to follow the privacy notice that is in effect at this time. We may tell you about any changes to our notice in a number of ways. We may tell you about the changes in a member newsletter or post them on our website. We may also mail you a letter that tells you about any changes.

Important legal information you should take time to read

Si necesita ayuda en espanol para entender este documento, puede solicitarla sin costo adicional, llamando al numero de servicio al cliente que aparece al dorso de su tarjeta de identificacion o en el folleto de inscripcion.

This Notice is provided by the following company: **Anthem Blue Cross and Blue Shield**

STATE NOTICE OF PRIVACY PRACTICES

As we told you in our HIPAA notice, we must follow state laws that are more strict than the federal HIPAA privacy law. This notice explains your rights and our legal duties under state law.

Your Personal Information

We may collect, use and share your nonpublic personal information (PI) as described in this notice.

We may collect PI about you from other persons or entities such as doctors, hospitals, or other carriers.

We may share PI with persons or entities outside of our company without your OK in some cases.

If we take part in an activity that would require us to give you a chance to opt-out, we will contact you. We will tell you how you can let us know that you do not want us to use or share your PI for a given activity.

You have the right to access and correct your PI.

Because PI is defined as any information that can be used to make judgements about your health, finances, character, habits, hobbies, reputation, career and credit, we take reasonable safety measures to protect the PI we have about you.

A more detailed state notice is available upon request. Please call the phone number printed on your ID card.

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Your rights and responsibilities

We are committed to:

- Recognizing and respecting you as a member.
- Encouraging your open discussions with your health care professionals and providers.
- Providing information to help you become an informed health care consumer.
- Providing access to health benefits and our network providers.
- Sharing our expectations of you as a member.

You have the right to:

- Participate with your health care professionals and providers in making decisions about your health care.
- Receive the benefits for which you have coverage.
- Be treated with respect and dignity.
- Privacy of your personal health information, consistent with state and federal laws, and our policies.
- Receive information about our organization and services, our network of health care professionals and providers, and your rights and responsibilities.
- Candidly discuss with your physicians and providers appropriate or medically necessary care for your condition, regardless of cost or benefit coverage.
- Make recommendations regarding the organization's members' rights and responsibilities policies.
- Voice complaints or appeals about: our organization, any benefit or coverage decisions we (or our designated administrators) make, your coverage, or care provided.
- Refuse treatment for any condition, illness or disease without jeopardizing future treatment, and be informed by your physician(s) of the medical consequences.
- Participate in matters of the organization's policy and operations.

Your rights and responsibilities (continued)

You have the responsibility to:

- Choose a participating primary care physician if required by your health benefit plan.
- Treat all health care professionals and staff with courtesy and respect.
- Keep scheduled appointments with your doctor, and call the doctor's office if you have a delay or cancellation.
- Read and understand to the best of your ability all materials concerning your health benefits or ask for help if you need it.
- Understand your health problems and participate, along with your health care professionals and providers in developing mutually agreed upon treatment goals to the degree possible.
- Supply, to the extent possible, information that we and/or your health care professionals and providers need in order to provide care.
- Follow the plans and instructions for care that you have agreed on with your health care professional and provider.
- Tell your health care professional and provider if you do not understand your treatment plan or what is expected of you.
- Follow all health benefit plan guidelines, provisions, policies and procedures.
- Let our Customer Service Department know if you have any changes to your name, address, or family members covered under your policy.
- Provide us with accurate and complete information needed to administer your health benefit plan, including other health benefit coverage and other insurance benefits you may have in addition to your coverage with us.

We are committed to providing quality benefits and customer service to our members. Benefits and coverage for services provided under the benefit program are governed by the Subscriber Agreement and not by this Member Rights and Responsibilities statement.

The most detailed description of benefits, exclusions and restrictions can be found in the following publications which are issued upon initial enrollment or at renewal. If you have questions, please contact your agent, Group Administrator, or member services at 800-451-1527 or 804-358-1551 if calling from the Richmond area: PP-INTRO (10/10), P-TOC (07/10), P-SB1 (10/10), P-SB2 (10/10), P-WORKS (10/10), P-COVERED (10/10), P-EXCL (10/10), P-CLAIMS (10/10), P-COB (07/10), P-ENR (10/10), P-ENDS (10/10), P-INFO-(10/07), P-RIGHTS (7/09), P-DEF (10/10), P-EXH-A (10/10), P-INDEX (07/10), P-ACC (07/10), GP-1 (7/02), GP-1-TOC, GP-1-ELIG (7/07), GP-1-GEN (1/08)

Enrollment applications used for Anthem KeyCare: 490760 (08/10), 490773 (08/10)

This is not a contract or policy. This brochure is not a contract with Anthem Blue Cross and Blue Shield. It is a summary of benefits available through Anthem KeyCare offered by Anthem Blue Cross and Blue Shield. If there is any difference between this brochure and the group policy, the provisions of the group policy will govern. Anthem Blue Cross and Blue Shield's service area for the sale of its policies is the Commonwealth of Virginia excluding the city of Fairfax, the town of Vienna and the area east of State Route 123. However, Anthem Blue Cross and Blue Shield's provider networks include doctors, hospitals and other health care professionals located in those areas and in other contiguous regions outside of the Anthem Blue Cross and Blue Shield service area.

For more information, please call Member Services at 800-451-1527 or 804-358-1551 from the Richmond calling area. Member Services may also be contacted at P.O. Box 27401 Richmond, VA 23279-7401.

Express Scripts, Inc. is a separate company that provides pharmacy services and pharmacy benefit management services on behalf of health plan members.

Visit us online at anthem.com

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