Evidence of Coverage

(Referred to as “EOC” in the following pages)

Anthem HealthKeepers Silver X POS 2000/20%

Offered by HealthKeepers, Inc.

This plan is a Health Maintenance Organization product.

HealthKeepers, Inc.

P.O. Box 26623

Richmond, VA 23261-6623

RIGHT TO EXAMINE

As a new *subscriber*, if *you* are not satisfied with this *evidence of coverage*, return it to *us* within ten (10) days after *you* receive it. The premium *you* paid will be promptly refunded, reduced by any amounts *we* paid in claims for *you*. If *you* return this *evidence of coverage* to *us* within ten (10) days, it will be as if no *evidence of coverage* was ever issued.

HealthKeepers, Inc.
Evidence of Coverage

This *Evidence of Coverage ("EOC")* fully explains *your* health care benefits. Treat it as *you* treat the owner's manual for *your* car -store it in a convenient place and refer to it whenever *you* have questions about *your* health care coverage.

Delivery of Documents

We will provide an identification card and an *EOC* for each *subscriber*.

Benefit Program

The benefits, terms and conditions of this *EOC* are applicable to individuals who are determined by the *exchange* to be *qualified individuals* for purposes of enrollment in a *qualified health plan (QHP)*.

Important Phone Numbers

Member Services

Please refer to the **Member Services Telephone Number** on *your* identification card.

Healthkeepers' Specialty Pharmacy Program

Please refer to the **Member Services Telephone Number** on *your* identification card.

How to Obtain Language Assistance

HealthKeepers, *Inc.* (*HealthKeepers*) is committed to communicating with *our* members about their health plan, no matter what their language is. *HealthKeepers* employs a language line interpretation service for use by all of *our* **Member Services** Call Centers. Simply call the **Member Services** phone number on the back of *your* identification card and a representative will be able to assist *you.* Telephone typewriter/Telecommunications Device for the Deaf (TTY/TDD) services are also available by dialing 711. A special operator will get in touch with us to help with *your* needs. Translation of written materials about *your* benefits can also be requested by contacting **Member Services**. In the event of a dispute, the provisions of the English version will control.

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente.

(If *you* need Spanish-language assistance to understand this document, *you* may request it at no additional cost by calling the **Member Services** number.)

Home Office Address:

You may visit our home office during normal business hours:

Monday through Friday – 8:00 a.m. to 5:00 p.m. at:

2015 Staples Mill Road

Richmond, VA 23230

Key words

There are a few key words *you* will see repeated throughout this *EOC.* In addition, *we* have included a **Definitions** section that lists various words referenced. A defined word will be **Italicized** each time it is used.

HealthKeepers, we, us, our

Refers to *HealthKeepers, Inc.*

Subscriber

is the primary applicant for coverage and his/her *dependents* (if any), who meet the eligibility requirements of this e*vidence of coverage* and enrolls in *HealthKeepers.*

Member

Any *subscriber* or enrolled *dependent*.

You, your

Any *subscriber* or *member.*

Outpatient

Care received in a *hospital outpatient* department, *emergency* room, professional *provider's* office, or *your* home.

Inpatient

Care received while *you* are a bed patient in the *hospital*.

Acknowledgement of Understanding

Subscriber, hereby expressly acknowledges his/her understanding that *evidence of coverage* constitutes a contract solely between *subscriber* and *Healthkeepers, Inc.* which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting *Healthkeepers, Inc.* to use the Blue Cross and/or Blue Shield Service Mark in a portion of the Commonwealth of Virginia, and that *Healthkeepers, Inc.* is not contracting as the agent of the Association. *Subscriber*, further acknowledges and agrees that it has not entered into this e*vidence of coverage* based upon representations by any person other than *Healthkeepers, Inc.* and that no person, entity, or organization other than *Healthkeepers, Inc.* shall be held accountable or liable to *subscriber*, for any of *Healthkeepers, Inc.* obligations to *subscriber*, created under this e*vidence of coverage*. This paragraph shall not create any additional obligations whatsoever on the part of *Healthkeepers, Inc.* other than those obligations created under other provisions of this agreement.

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Schedule of Cost Shares & Benefits

This chart is an overview of *your* benefits for *covered services*, which are listed in detail in the **"What Is Covered"** section. A list of services that are not covered can be found in the **"What Is Not Covered"** (Exclusions) section.

What will I pay?

This chart shows the most *you* pay for *cost-shares* and *your out-of-pocket limit* for *covered services* in a calendar year. This chart also shows *your* benefit limits for certain services.

The *deductible* applies to all *covered services*, except for:

- In-network Preventive Care Services, required by law
- *Covered services* listed in the chart below, which specifically indicate that the *deductible* does not apply

Any charges over *our maximum allowed amount,* do not count towards satisfying *your out-of-pocket limit*.

For a detailed explanation of how *your* calendar year *cost-shares*, *out-of-pocket limit(s)* and *maximum allowed amounts* are calculated, please see the **"Claims and Payment"** section.

Your plan is a **Point of Service (POS) plan**. The plan has two sets of benefits: in-network and out-of network. If *you* choose an in-network *provider*, *you* will pay less in out-of-pocket costs, such as *copayments*, *deductibles*, and *coinsurance*. If *you* use an out-of-network *provider*, *you* will have to pay more out-of-pocket costs.

In addition, *we* have designated certain in-network *hospitals* as participating in Tier 1 or Tier 2. *We* have agreements in place with these *hospitals* to receive discounts on services; however, depending on the category, *your* in-network *coinsurance* may be different. *Tier 1 hospitals* have lower costs to *members* than *Tier 2 hospitals*. If *you* go to an out-of-network *hospital*, there is no agreement on the cost of services, nor any designation as to *Tier 1/Tier 2 hospitals*. Therefore, *you* are responsible for a separate out-of-network *deductible* and *out-of-pocket limit*, in addition to, higher out-of-pocket *cost-shares*, and *you* may be billed for amounts above our *maximum allowed amount*.

Note: If *you* receive services under the BlueCard program, those services will be subject to the out-of-network *cost-shares* detailed on the **Schedule of Cost Shares & Benefits**.

Plan Features

Deductible	**In-Network Member Pays**	**Out-of-Network Member Pays**
Individual	$2,000	$4,000
Family	$4,000	$8,000
The in-network and out-of-network *deductibles* accumulate separately and do not count towards satisfying each other.		
The individual *deductible* amount applies separately to each covered *member*, per calendar year. If *you*, the *subscriber*, are the only person covered by this *EOC*, then only the individual *deductible* amount(s) apply. If *you* have family members covered under this *EOC*, the family *deductible* amount is the dollar amount that must be satisfied, per calendar year. Once two or more covered family members' individual		

deductibles combine to equal the family *deductible* amount, then the calendar year family *deductible* will be satisfied. No one *member* can contribute more than their individual *deductible* amount to the family *deductible*.

Coinsurance	**In-Network Member Pays**	**Out-of-Network Member Pays**
Coinsurance Percentage (unless otherwise specified below)	20% Coinsurance	30% Coinsurance

Out-of-Pocket Limit Includes *deductible*, *copayments* and *coinsurance*	**In-Network Member Pays**	**Out-of-Network Member Pays**
Individual	$6,850	$12,000
Family	$13,700	$24,000
The in-network and out-of-network *out-of-pocket limits* accumulate separately and do not count towards satisfying each other.		
The individual *out-of-pocket limit* applies separately to each covered *member*, per calendar year. If *you*, the *subscriber*, are the only person covered by this *EOC*, then only the individual *out-of-pocket* amount(s) apply. If *you* have family members covered under this *EOC*, the family *out-of-pocket limit* is the dollar amount that must be satisfied, per calendar year. Once two or more covered family members' *out-of-pocket limits* combine to equal the family *out-of-pocket limit*, then the calendar year family *out-of-pocket limit* will be satisfied. No one *member* can contribute more than their individual *out-of-pocket limit* to the family *out-of-pocket limit*.		

IMPORTANT: *You* are responsible for confirming that the *provider you* are seeing or have been referred to see is an in-network *provider* under this *EOC*. It is important to understand that *Healthkeepers* has many contracting *providers*, who may not be part of the network of *providers*, which applies to this *EOC*. The name of the network for this plan is located on *your* identification card.

***We* can help *you* find an in-network *provider* specific to *your EOC*, by calling the number on the back of *your* identification card.**

Medical Services

Medical Services	In-Network Member Pays	Out-of-Network Member Pays
Allergy Injections	$0 Copayment 20% Coinsurance	$0 Copayment 30% Coinsurance
Allergy Testing	$0 Copayment 20% Coinsurance	$0 Copayment 30% Coinsurance
Ambulance Services (Emergency) Out-of-network *allowed amounts* are subject to in-network *cost-sharing*, and count towards satisfying the in-network *out-of-pocket limit*.	$0 Copayment 20% Coinsurance	$0 Copayment 20% Coinsurance
Ambulance Services (Non-Emergency) Benefits for non-*emergency* ambulance services will be limited to $50,000 per occurrence if an out-of-network *provider* is used.	$0 Copayment 20% Coinsurance	$0 Copayment 30% Coinsurance
Dental Accident Services (*Covered services* related to accidental dental injury)	*Cost-share(s)* determined based on type of service & where services are rendered.	$0 Copayment 30% Coinsurance
Diabetic Medical Supplies, Equipment, & Education	*Cost-share(s)* determined based on type of service & where services are rendered.	$0 Copayment 30% Coinsurance
Outpatient Diagnostic Laboratory and Pathology Services		
Tier 1 Hospital	$0 Copayment 20% Coinsurance	$0 Copayment 30% Coinsurance
Tier 2 Hospital	$0 Copayment 50% Coinsurance	$0 Copayment 30% Coinsurance
Freestanding Facility or Physician's Office	$0 Copayment 20% Coinsurance	$0 Copayment 30% Coinsurance
Outpatient Diagnostic Imaging Services and Electronic Diagnostic Tests		
Tier 1 Hospital	$0 Copayment 20% Coinsurance	$0 Copayment 30% Coinsurance

Medical Services	In-Network Member Pays	Out-of-Network Member Pays
Tier 2 Hospital	$0 Copayment 50% Coinsurance	$0 Copayment 30% Coinsurance
Freestanding Facility or Physician's Office	$0 Copayment 20% Coinsurance	$0 Copayment 30% Coinsurance
Outpatient Advanced Imaging Services		
Tier 1 Hospital	$0 Copayment 20% Coinsurance	$0 Copayment 30% Coinsurance
Tier 2 Hospital	$0 Copayment 50% Coinsurance	$0 Copayment 30% Coinsurance
Freestanding Facility or Physician's Office	$0 Copayment 20% Coinsurance	$0 Copayment 30% Coinsurance
Doctor Office Visits		
Primary Care Physician (PCP) Office Visits In-network *copayment* applies to *PCP* office *visit* charge only. (*Copayments* for *primary care physician* office visits do not count towards satisfying the *deductible*.)	$20 Copayment for the first 5 visits combined with Specialty Care Physician visits (Deductible does not apply) 20% Coinsurance for visits 6 and after (Deductible does apply)	$0 Copayment 30% Coinsurance
Specialty Care Physician (SCP) Office Visits In-network *copayment* applies to SCP office *visit* charge only. (*Copayments* for *specialty care physician* office visits do not count towards satisfying the *deductible*.) **Important:** The In-network 5 *visit* limitation is a combined number of visits shared between *PCP* and SCP office *visits*. After the combined 5 *visit* limitation is exhausted, subsequent office *visits* are then subject to the *deductible* and *coinsurance*.	$65 Copayment for the first 5 visits combined with Primary Care Physician visits (Deductible does not apply) 20% Coinsurance for visits 6 and after (Deductible does apply)	$0 Copayment 30% Coinsurance
Other Office Services	$0 Copayment 20% Coinsurance	$0 Copayment 30% Coinsurance
Durable Medical Equipment (medical supplies and equipment)	$0 Copayment 20% Coinsurance	$0 Copayment 30% Coinsurance

Medical Services	In-Network Member Pays	Out-of-Network Member Pays
Early Intervention Services (For *dependent* children from birth to age 3)	$0 Copayment 20% Coinsurance	$0 Copayment 30% Coinsurance
Emergency Room (ER) Facility Out-of-network *allowed amounts* are subject to in-network *cost-sharing*, and count towards satisfying the in-network *out-of-pocket limit*.	$0 Copayment 40% Coinsurance	$0 Copayment 40% Coinsurance
ER Physician & Professional Services Out-of-network *allowed amounts* are subject to in-network *cost-sharing*, and count towards satisfying the in-network *out-of-pocket limit*.	$0 Copayment 40% Coinsurance	$0 Copayment 40% Coinsurance
Home Health Care Limited to a maximum of 100 visits per *member*, per calendar year.	$0 Copayment 20% Coinsurance	$0 Copayment 30% Coinsurance
Private duty nursing care provided in the home setting is limited to a maximum of 16 hours per *member*, per calendar year	$0 Copayment 20% Coinsurance	$0 Copayment 30% Coinsurance
Hospice Care	$0 Copayment 20% Coinsurance	$0 Copayment 30% Coinsurance
Hospital & Surgical Services		
Inpatient		
Tier 1 Hospital	$0 Copayment 20% Coinsurance	$0 Copayment 30% Coinsurance
Tier 2 Hospital	$0 Copayment 50% Coinsurance	$0 Copayment 30% Coinsurance
Freestanding Facility	$0 Copayment 20% Coinsurance	$0 Copayment 30% Coinsurance
Professional Surgery Services	$0 Copayment 20% Coinsurance	$0 Copayment 30% Coinsurance

Medical Services	In-Network Member Pays	Out-of-Network Member Pays
Other Physician & Professional Services	$0 Copayment 20% Coinsurance	$0 Copayment 30% Coinsurance
Hospital & Surgical Services		
Outpatient		
Tier 1 Hospital	$0 Copayment 20% Coinsurance	$0 Copayment 30% Coinsurance
Tier 2 Hospital	$0 Copayment 50% Coinsurance	$0 Copayment 30% Coinsurance
Freestanding Facility/ Ambulatory Surgical Center	$0 Copayment 20% Coinsurance	$0 Copayment 30% Coinsurance
Professional Surgery Services	$0 Copayment 20% Coinsurance	$0 Copayment 30% Coinsurance
Other Physician & Professional Services	$0 Copayment 20% Coinsurance	$0 Copayment 30% Coinsurance
Lymphedema	*Cost-share(s)* determined based on type of service & where services are rendered.	$0 Copayment 30% Coinsurance
Maternity Services		
Inpatient		
Tier 1 Hospital	$0 Copayment 20% Coinsurance	$0 Copayment 30% Coinsurance
Tier 2 Hospital	$0 Copayment 50% Coinsurance	$0 Copayment 30% Coinsurance
Freestanding Facility	$0 Copayment 20% Coinsurance	$0 Copayment 30% Coinsurance
Physician & Professional Services	$0 Copayment 20% Coinsurance	$0 Copayment 30% Coinsurance
Outpatient		
Tier 1 Hospital	$0 Copayment 20% Coinsurance	$0 Copayment 30% Coinsurance

Medical Services	In-Network Member Pays	Out-of-Network Member Pays
Tier 2 Hospital	$0 Copayment 50% Coinsurance	$0 Copayment 30% Coinsurance
Freestanding Facility	$0 Copayment 20% Coinsurance	$0 Copayment 30% Coinsurance
Physician & Professional Services	$0 Copayment 20% Coinsurance	$0 Copayment 30% Coinsurance
Office Services (separate from global services)	$0 Copayment 20% Coinsurance	$0 Copayment 30% Coinsurance
Mental Health & Substance Abuse		
Inpatient		
Tier 1 Hospital	$0 Copayment 20% Coinsurance	$0 Copayment 30% Coinsurance
Tier 2 Hospital	$0 Copayment 50% Coinsurance	$0 Copayment 30% Coinsurance
Freestanding Facility	$0 Copayment 20% Coinsurance	$0 Copayment 30% Coinsurance
Physician & Professional Services	$0 Copayment 20% Coinsurance	$0 Copayment 30% Coinsurance
Outpatient		
Tier 1 Hospital	$0 Copayment 20% Coinsurance	$0 Copayment 30% Coinsurance
Tier 2 Hospital	$0 Copayment 50% Coinsurance	$0 Copayment 30% Coinsurance
Freestanding Facility	$0 Copayment 20% Coinsurance	$0 Copayment 30% Coinsurance
Office Visits	$0 Copayment 20% Coinsurance	$0 Copayment 30% Coinsurance
Outpatient Therapy Services		
Tier 1 Hospital	$0 Copayment 20% Coinsurance	$0 Copayment 30% Coinsurance

Medical Services	In-Network Member Pays	Out-of-Network Member Pays
Tier 2 Hospital	$0 Copayment 50% Coinsurance	$0 Copayment 30% Coinsurance
Freestanding Facility or Physician's Office	$0 Copayment 20% Coinsurance	$0 Copayment 30% Coinsurance
Chemotherapy, Radiation, and Respiratory Therapy **Cardiac Rehabilitation Therapy** **Physical & Occupational Therapy** All *outpatient* rehabilitative and *habilitative services* combined, limited to **30 *visits***, per *member*, per calendar year **Speech Therapy** All *outpatient* rehabilitative and *habilitative services* combined, limited to **30 *visits*** per *member*, per calendar year **Spinal Manipulation and Manual Medical Therapy Services** **30 *visits*** per *member*, per calendar year. Services must be rendered by a participating American Specialty Health Group (ASHG) provider.	$0 Copayment 20% Coinsurance	$0 Copayment 30% Coinsurance
Note: If during the course of one *visit*, multiple types of service are received, where those types of service carry separate benefit *visit* limits (e.g., physical therapy and a spinal manipulation), the one *visit* may count against both limits.		
Preventive Care (Wellness) Services Preventive care, screenings and immunization services for infants, children, adolescents and adults	$0 Copayment 0% Coinsurance (Deductible does not apply)	$0 Copayment 30% Coinsurance
Prosthetics (prosthetic devices, their repair, fitting, replacement and components)	$0 Copayment 20% Coinsurance	$0 Copayment 30% Coinsurance
Skilled Nursing Care Limited to a maximum of **100 days** per stay **Inpatient**		

Medical Services	In-Network Member Pays	Out-of-Network Member Pays
Tier 1 Hospital	$0 Copayment 20% Coinsurance	$0 Copayment 30% Coinsurance
Tier 2 Hospital	$0 Copayment 50% Coinsurance	$0 Copayment 30% Coinsurance
Freestanding Facility	$0 Copayment 20% Coinsurance	$0 Copayment 30% Coinsurance
Telemedicine Services	*Cost-share(s)* determined based on type of service & where services are rendered.	$0 Copayment 30% Coinsurance
Temporomandibular and Craniomandibular Joint Treatment	*Cost-share(s)* determined based on type of service & where services are rendered.	$0 Copayment 30% Coinsurance
Transplant Human Organ & Tissue **Network only - Transplant Transportation and Lodging** **$10,000** maximum benefit limit per transplant **Unrelated Donor Search** **$30,000** maximum benefit limit per transplant	*Cost-share(s)* determined based on type of service & where services are rendered.	$0 Copayment 30% Coinsurance
Urgent Care Center Out-of-network *allowed amounts* are subject to in-network *cost-sharing*, and count towards satisfying the in-network *out-of-pocket limit*.	$0 Copayment 20% Coinsurance	$0 Copayment 20% Coinsurance

Prescription Drugs

Prescriptions are subject to the medical *deductible*, unless otherwise specified below.

Retail Pharmacy Prescription Drugs (30-day supply per prescription)	**In-Network** **Member Pays**	**Out-of-Network** **Member Pays**
Tier 1	$15 Copayment 0% Coinsurance (Deductible does not apply)	$0 Copayment 30% Coinsurance
Tier 2	$50 Copayment 0% Coinsurance (Deductible does not apply)	$0 Copayment 30% Coinsurance
Tier 3	$0 Copayment 20% Coinsurance	$0 Copayment 30% Coinsurance
Tier 4	$0 Copayment 20% Coinsurance	$0 Copayment 30% Coinsurance
Coverage is limited to those d*rugs* listed on our *prescription drug* list (*formulary*).		
Specialty drugs are NOT covered out-of-network.		

Mail Order Prescription Drugs (90-day supply per prescription for all *drugs* except for ***specialty drugs*** **and drugs on *Tier 4*, which are limited to a 30-day supply per prescription.)**	**In-Network** **Member Pays**	**Out-of-Network** **Member Pays**
Tier 1	$30 Copayment 0% Coinsurance (Deductible does not apply)	Not Covered
Tier 2	$125 Copayment 0% Coinsurance (Deductible does not apply)	Not Covered
Tier 3	$0 Copayment 20% Coinsurance	Not Covered
Tier 4	$0 Copayment 20% Coinsurance	Not Covered
Coverage is limited to those d*rugs* listed on our *prescription drug* list (*formulary*).		

Pediatric Dental Services

The following dental benefits are available to *members* through the end of the month in which they turn age 19. Covered dental services are subject to the medical calendar year *deductible*, except as otherwise specified below.

Please see the pediatric dental services provisions in the *covered services* section of this *EOC* for detailed descriptions of services.

Pediatric Dental Care	In-Network Member Pays	Out-of-Network Member Pays
Diagnostic and Preventive Services (Deductible does not apply)	10% Coinsurance	30% Coinsurance
Basic Restorative Services	40% Coinsurance	50% Coinsurance
Oral Surgery Services	50% Coinsurance	50% Coinsurance
Endodontic Services	50% Coinsurance	50% Coinsurance
Periodontal Services	50% Coinsurance	50% Coinsurance
Major Restorative Services	50% Coinsurance	50% Coinsurance
Prosthodontic Services	50% Coinsurance	50% Coinsurance
Dentally Necessary Orthodontic Services	50% Coinsurance	50% Coinsurance

Pediatric Vision Services

The following benefits are available to *members* through the end of the month in which they turn age 19. Covered pediatric vision services are **not** subject to the medical calendar year *deductible*.

To get the in-network benefits, *you* must use a Blue View Vision *provider*. If *you* need help finding a Blue View Vision *provider*, please visit *our* website or call the number on *your* ID card.

Out-of-network *providers* may bill *you* for any charges that exceed the plan's *maximum allowed amount*.

Pediatric Vision Care	In-Network Member Pays	Out-of-Network Member Pays
Routine Eye Exam Once every Calendar Year	$0 Copayment	$0 Copayment Covered up to the maximum allowed amount
Standard Plastic Lenses* Once Every Calendar Year		
Single Vision	$0 Copayment	$0 Copayment Covered up to the maximum allowed amount
Bifocal	$0 Copayment	$0 Copayment Covered up to the maximum allowed amount
Trifocal	$0 Copayment	$0 Copayment Covered up to the maximum allowed amount
Progressive	$0 Copayment	$0 Copayment Covered up to the maximum allowed amount
Lenses include factory scratch coating, UV coating, standard polycarbonate and standard photochromic lenses at no additional cost when received from in network providers.		
Frames*(formulary) This plan offers a selection of covered frames. Once every Calendar Year	$0 Copayment	$0 Copayment Covered up to the maximum allowed amount
Contact Lenses*(formulary) This plan offers a selection of covered contact lenses. Once every Calendar Year		
Elective (conventional and disposable)	$0 Copayment	$0 Copayment Covered up to the maximum allowed amount
Non-Elective	$0 Copayment	$0 Copayment Covered up to the maximum allowed amount

*If *you* receive elective or non-elective contact lenses then no benefits will be available for eyeglass lenses until *you* satisfy the benefit frequency listed.

Eligible *American Indians*, as determined by the *exchange*, are exempt from cost sharing requirements when *covered services* are rendered by an Indian Health Service (IHS), Indian Tribe, Tribal organization, or Urban Indian Organization (UIO) or through referral under contract health services. There will be no *member* responsibility for *American Indians* when *covered services* are rendered by one of these *providers*.

How Your Coverage Works

Your coverage provides a wide range of health care services. The information contained in this section is designed to help *you* understand how *you* can access *your* benefits. For more specific information on *deductibles*, *copayments, coinsurance,* and benefit limits, please refer to *your* **Schedule of Cost Shares and Benefits.**

Carry Your Identification Card

Your coverage identification (ID) card identifies *you* as a *member* and contains important health care coverage information. Carrying *your* card at all times will ensure *you* always have access to this coverage information with *you* when *you* need it. Make sure *you* show *your* ID card to *your* doctor, *hospital*, pharmacist, or other health care *provider* so they know you're a *HealthKeepers member.* Network *providers* have agreed to submit claims to *us* on *your* behalf.

How to Find a Provider in the Network

There are three ways *you* can find out if a *provider* or *facility* is in the network for this plan. *You* can also find out where they are located and details about their license or training. *Your* network is shown on the front of *your* identification card.

- See *your* plan's directory of in-network *providers* at www.anthem.com, which lists the doctors, *providers,* and *facilities* that participate in this plan's network. To locate in-network *providers*, select "Find A Doctor," choose the type of *provider* you are searching for, your location, and under "What insurance plan would you like to use," select the network name outlined on the front of *your* identification card.
- Call **Member Services** to ask for a list of doctors and *providers* that participate in this plan's network, based on specialty and geographic area.
- Check with *your* doctor or *provider*.

If you need details about a *provider's* license or training, or help choosing a doctor who is right for *you*, call the **Member Services** number on the back of *your member* ID card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with *us* to help with *your* needs.

First - Make an Office Visit with Your *PCP*

Your PCP's job is to help *you* stay healthy, not just treat *you* when *you* are sick. After *you* pick a *PCP* set up an office *visit*. During this *visit*, get to know *your PCP* and help *your PCP* get to know *you*. *You* should talk to *your PCP* about:

- *Your* personal health history,
- *Your* family health history,
- *Your* lifestyle, and
- Any health concerns *you* have.

If *you* do not get to know *your PCP*, he or she may not be able to properly manage *your* care. To see a doctor, call their office:

- Tell them *you* are a *HealthKeepers member*,
- Have *your member* ID card handy. The doctor's office may ask *you* for *your member* ID number.
- Tell them the reason for *your visit*.

When *you* go to the office, be sure to bring *your member* ID card with *you*.

If *you* need to see a specialist, *you* can visit any in-network specialist including a behavioral health *provider*. *You* do not have to get a *referral*.

If *you* have any questions about *covered services*, call *us* at the telephone number listed on *your* ID card.

Requesting Approval for Benefits

To receive full benefits for covered *inpatient* hospitalization services *you*, a friend, a family member, *your provider* or *facility* must call *us* to receive admission approval for the proposed service.

Prior Authorization: Network *providers* must obtain Prior Authorization in order for *you* to get benefits for certain services. Prior Authorization criteria will be based on many sources including medical policy, clinical guidelines, and *pharmacy and therapeutics* guidelines. *We* may decide that a service that was prescribed or asked for is not *medically necessary* if *you* have not first tried other *medically necessary* and more cost effective treatments.

If *you* have any questions about the information in this section, *you* may call the **Member Services** phone number on the back of *your* ID Card.

Types of Requests

- **Precertification** – A required review of a service, treatment or admission for a benefit coverage determination which must be done before the service, treatment or admission start date. For *emergency* admissions, *you*, *your* authorized representative or doctor must tell *us* within 48 hours of the admission or as soon as possible within a reasonable period of time. For labor / childbirth admissions, precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time.

- **Predetermination** – An optional, voluntary Prospective or Continued Stay Review request for a benefit coverage determination for a service or treatment. *We* will check *your EOC* to find out if there is an exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to decide whether the service meets the definition of *medical necessity* under this *EOC* or is *experimental/investigative* as that term is defined in this *EOC*.

- ***Post Service* Clinical Claims Review** – A Retrospective Review for a benefit coverage determination to decide the *medical necessity* or *experimental/investigative* nature of a service, treatment or admission that did not need precertification and did not have a predetermination review performed. Medical reviews are done for a service, treatment or admission in which *we* have a related clinical coverage guideline and are typically initiated by *us*.

Typically, in-network *providers* know which services need precertification and will get any precertification or ask for a predetermination when needed. *Your primary care physician* and other in-network *providers* have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering *provider*, *facility* or attending doctor will get in touch with *us* to ask for a precertification or predetermination review ("requesting *provider*"). *We* will work with the requesting *provider* for the precertification request. However, *you* may choose an authorized representative to act on *your* behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

Who is responsible for Precertification	
Services given by an in-network *provider*	**Services given by a BlueCard/out-of-network/non-participating *provider***
Provider	• *Member* must get precertification. • If *member* fails to get precertification, *member* may be financially responsible for service and/or setting in whole or in part. • For *emergency* admissions, *you*, *your* authorized representative or doctor must tell us within 48 hours of the admission or as soon as possible within a reasonable period of time.

We will use *our* clinical coverage guidelines, such as medical policy and other internally developed clinical guidelines, procedures, and preventative care clinical coverage guidelines, to help make *our medical necessity* decisions, including decisions about *prescription* and *specialty drug* services. *We* reserve the right to review and update these clinical coverage guidelines from time to time. *We* will administer benefits for any *medically necessary* determination, as decided solely by *us*, notwithstanding that it might otherwise be found to be *investigational* as that term is defined in the *EOC*, otherwise. Nothing shall prevent *you* from appealing our decision that a service is not *medically necessary*. *Your EOC* takes precedence over these guidelines.

You are entitled to ask for and get, free of charge, reasonable access to any records on which *we* based *our* determination. To ask for this information, call the precertification phone number on the back of *your* ID card.

We may, from time to time, waive, enhance, modify or discontinue certain medical management processes (including utilization management, case management, and disease management) if in *our* discretion, such change is in furtherance of the provision of cost effective, value based and/or quality services.

In addition, *we* may select certain qualifying *providers* to participate in a program that exempts them from certain procedural or medical management processes that would otherwise apply. *We* may also exempt *you* claim from medical review if certain conditions apply.

Just because *we* exempt a process, *provider* or claim from the standards which otherwise would apply, it does not mean that *we* will do so in the future, or will do so in the future for any other *provider*, claim or insured. *We* may stop or modify any such exemption with or without advance notice.

You may determine whether a *provider* is participating in certain programs by checking *your* on-line *provider d*irectory, on-line pre-certification list or contacting **Member Services** at the number on *your* ID card.

We also may identify certain *providers* to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a *provider* is selected under this program, then *we* may use one or more clinical utilization management guidelines in the review of claims submitted by this *provider*, even if those guidelines are not used for all *providers* delivering services to *our members*.

Request Categories

- ***Emergency***– A request for precertification or predetermination that in the view of the treating *provider* or any doctor with knowledge of *your* medical condition, could without such care or treatment, seriously threaten *your* life or health or *your* ability to regain maximum function or subject *you* to severe pain that cannot be adequately managed without such care or treatment.

- **Prospective** – A request for precertification or predetermination that is conducted before the service, treatment or admission.

- **Continued Stay Review** - A request for precertification or predetermination that is conducted during the course of treatment or admission.

- **Retrospective** - A request for approval that is made after the service, treatment or admission has happened. *Post service* clinical claims reviews are also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, accuracy of documentation, or coding, or adjudication of payment.

Decision and Notice Requirements

We will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on *state* and federal laws. Where *state* laws are stricter than federal laws, *we* will follow *state* laws. If *you* live in and/or get services in a *state* other than the *state* where *your EOC* was issued other *state*-specific requirements may apply. *You* may call the phone number on the back of *your* ID card for more details.

Request Category	**Timeframe Requirement for Decision and Notification**
Prospective *Emergency*	72 hours from the receipt of request
Prospective Non-*Emergency*	15 calendar days from the receipt of the request
Continued Stay Review when hospitalized at the time of the request	72 hours from the receipt of the request and prior to expiration of current certification.
Continued Stay Review *Emergency* when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Continued Stay Review *Emergency* when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Continued Stay Review Non-*Emergency*	15 calendar days from the receipt of the request
Retrospective	30 calendar days from the receipt of the request

If more information is needed to make *our* decision, *we* will tell the requesting *provider* and send written notice to *you* or *your* authorized representative of the specific information needed to finish the review. If *we* do not get the specific information *we* need or if the information is not complete by the timeframe identified in the written notice, *we* will make a decision based upon the information *we* have.

We will give notice of *our* decision as required by *state* and federal law. Notice may be given by the following methods:

Verbal: Oral notice given to the requesting *provider* by phone or by electronic means if agreed to by the *provider*.

Written: Mailed letter or electronic means including email and fax given to, at a minimum, the requesting *provider* and *you* or *your* authorized representative.

Precertification does not guarantee coverage for or payment of the service or treatment reviewed. For benefits to be covered, on the date *you* get service:

1. *You* must be eligible for benefits;
2. *Premium* must be paid for the time period that services are given;
3. The service or supply must be a covered benefit under *your EOC*;
4. The service cannot be subject to an exclusion under *your EOC*; and
5. *You* must not have exceeded any applicable limits under *your EOC*.

Health Plan Individual Case Management

Our health plan case management programs (case management) help coordinate services for *members* with health care needs due to serious, complex, and/or chronic health conditions. *Our* programs coordinate benefits and educate *member*s who agree to take part in the case management program to help meet their health-related needs.

Our case management programs are confidential and voluntary and are made available at no extra cost to you. These programs are provided by, or on behalf of and at the request of, your health plan case management staff. These case management programs are separate from any *covered services you* are receiving.

If *you* meet program criteria and agree to take part, *we* will help *you* meet *your* identified health care needs. This is reached through contact and team work with *you* and/or *your* chosen representative, treating doctor(s), and other *providers*.

In addition, *we* may assist in coordinating care with existing community-based programs and services to meet *your* needs. This may include giving *your* information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, *we* may provide benefits for alternate care that is not listed as a *covered service*. *We* may also extend *covered services* beyond the benefit maximums of this *EOC*. *We* will make *our* decision case-by-case, if in *our* discretion the alternate or extended benefit is in the best interest of the *member* and *HealthKeepers.* Nothing in this provision shall prevent *you* from appealing our decision. A decision to provide extended benefits or approve alternate care in one case does not obligate *us* to provide the same benefits again to *you* or to any other *member*. *We* reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, *we* will notify *you* or *your* representative in writing.

Approvals of Care Involving an Ongoing Course of Treatment

Network *providers* must follow certain procedures to ensure that if a previously approved course of treatment needs to be extended, the extension is requested in time to minimize disruption of needed services. If *you* are receiving care from a non-network *provider* and need to receive an extension of a previously approved course of treatment, *you* will be required to ask for the extension. *You* should request the extension at least 24 hours prior to the end of the authorized timeframe to avoid disruption of care or services. *We* will notify *you* of *our* coverage decision within 24 hours of *your* request.

If *we* make a determination to reduce or terminate benefits for all or any part of a previously approved course of treatment prior to its conclusion, this will be considered an *adverse benefit determination.* If the reduction or termination was not a result of a health plan amendment or health plan termination, *we* will notify *you* in advance of the reduction or termination in sufficient time for *you* to file an internal appeal prior to the reduction or termination.

Terminated Providers

Our network is subject to change as health care *providers* are added to the network, move, retire, or change their status. When *providers* decide to leave the network, they become non-participating *providers*, and services, unless properly authorized, will not be covered.

There are three instances when *members* may continue seeing *providers* who have left the network:

1) Terminated *providers* may continue to treat a *member* for 90 days, if the *member* is under an active course of treatment with the *provider*, if the *member* requests such continuing care, and if the *provider* has not been terminated for cause.
2) A *member* in the second or third trimester of pregnancy may continue seeing her obstetrician-gynecologist through postpartum care for that delivery.
3) *Members* with life expectancy of six months or less may continue seeing their treating physician.

The difference between emergency care and urgent care

An *emergency* is the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity including severe pain that, without immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in:

- serious jeopardy to the *mental* or physical health of the individual;
- danger of serious impairment of the individual's body functions;
- serious dysfunction of any of the individual's bodily organs; or
- in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Often an urgent rather than an *emergency* health problem exists. An urgent health problem is an unexpected illness or injury that calls for care that cannot wait until a regularly scheduled office *visit*. Urgent health problems are not life threatening and do not call for the use of an emergency room. Urgent health problems include earache, sore throat, and fever (not above 104 degrees).

Benefits for urgent care include:

- X-ray services;
- Tests such as flu, urinalysis, pregnancy test, rapid strep;
- Lab services;
- Stitches for simple cuts; and
- Draining an abscess.

Urgent care situations are usually marked by the rapid onset of persistent or unusual discomfort associated with an illness or injury. Examples of *urgent care situations* include high fever, vomiting, sprains or minor cuts.

If *you* cannot contact *your* PCP or are unsure if *your* condition requires *emergency* or urgent care, the 24/7 NurseLine is available to assist you 7 days a week. Please see the number on *your* ID Card.

After Hours Care

- If *you* need care after normal business hours, *your* doctor may have several options for *you*. *You* should call *your* doctor's office for instructions if *you* need care in the evenings, on weekends, or during the holidays and cannot wait until the office reopens.

- If *your* condition is an *emergency, you* should be taken to the nearest appropriate medical *facility*. In the event of an *emergency* call 911.

- *Your* coverage includes benefits for services rendered by *providers* other than in-network *providers* when the condition treated is an *emergency* as defined in this *EOC.*

When *you* are away from home (outside the service area) and need to access care

HealthKeepers does business only within a certain geographic area in the Commonwealth of Virginia. See **The BlueCard Program** below for *covered services* received outside of Virginia. *Urgent care situations* and *emergency* services outside the *service area* are provided to help *you* if *you* are injured or become ill while temporarily away from the *service area.* In order to receive in-plan benefits for these services, medical care must be required immediately and unexpectedly. In-plan benefits for maternity care are not available for normal term delivery outside the *service area.* However, in-plan benefits are available for earlier complications of pregnancy or unexpected delivery occurring outside the *service area.*

If an *emergency* or *urgent care situation* occurs when *you* are temporarily outside the *service area:*

- *you* should obtain care at the nearest medical *facility*;
- *you* will be responsible for payment of charges at the time of *your visit;* and
- *you* should obtain a copy of the complete itemized bill for filing a claim with *us.* For more information on filing claims see **When Y*ou* Must File a Claim** in this *EOC***.**

Inter-Plan Arrangements

Out-of-area Services

HealthKeepers has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. These are referred to generally as "Inter-Plan Programs." When *you* obtain *covered services* outside of *HealthKeepers*' *service area*, the claims may be processed through one of these Inter-Plan Programs. These programs include the BlueCard Program, described below. They may also include negotiated national account arrangements between *HealthKeepers* and other Blue Cross and Blue Shield Licensees.

Typically, when *you* access medical care outside *HealthKeepers' service area*, *you* will obtain it from *providers* that have a contractual agreement (i.e., are "participating *providers*") with the local Blue Cross and/or Blue Shield Licensee in that other area ("Host Blue"). But in some cases, *you* may obtain care from non-participating *providers*. *HealthKeepers'* payment practices in both cases are generally described below.

BlueCard® Program

Under the BlueCard Program, when *you* obtain out-of-area *covered services* and supplies within the geographic area served by a Host Blue, *we* will remain responsible for fulfilling its contractual obligations. But the Host Blue is responsible for: (a) contracting with its participating *providers*; and (b) handling interactions with those *providers*.

Whenever *you* obtain *covered services* or supplies outside *HealthKeepers' service area* and the claim is processed through the BlueCard Program, the amount *you* pay for them, if not a *copayment*, is calculated based on the lower of:

- The billed covered charges for the *covered services* or supplies; or
- The negotiated price that the Host Blue makes available to *us*.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the *provider*. Sometimes it is an estimated price that takes into account a special arrangement with that *provider* or *provider* group. Sometimes, such an arrangement may be an average price, based on a discount that results in expected average savings for services provided by similar types of *providers*. Estimated and average pricing arrangements may also involve: types of settlements; incentive payments; and/or other credits or charges.

Estimated and average pricing arrangements also take into account certain adjustments to their basic rates. These may be made to correct for an over- or underestimation of changes of the past pricing for the

types of transactions noted above. But, such adjustments will not affect the price on the claim that *HealthKeepers* will use to determine the amount *you* pay.

Also, federal law or the law in a small number of *states* may require the Host Blue to add a surcharge to a claim calculation. If federal law or any *state* law mandates other liability calculation methods, including a surcharge, *HealthKeepers* calculates a *member's* liability for any *covered service* according to applicable law.

Non-Participating Healthcare Providers Outside Our Service Area

Member Liability Calculation

When *you* obtain *covered services* from non-participating healthcare *providers* outside of *our service area*, the amount *you* pay for the services and supplies will generally be based on either: (a) the Host Blue's non-participating *provider* local payment; or (b) the pricing arrangements required by applicable *state* law. In these cases, *you* may be responsible for the difference between: (a) the amount that the non-participating *provider* bills; and (b) the payment *we* make for the *covered services*.

In some cases, *we* may pay such claims differently than described above. For example, *HealthKeepers'* payment for *covered services* obtained from non-participating *providers* could be made based on: (a) billed covered charges; (b) the payment *HealthKeepers* would make if the *covered services* had been obtained within its *service area*; or (c) a special negotiated payment, as allowed under Inter-Plan Program rules. In these cases, *you* may be liable for the difference between: (a) the amount that the non-participating healthcare *provider* bills; and (b) the payment *we* will make for the *covered services*.

Travel Outside the United States – BlueCard Worldwide

If *you* plan to travel outside the United States, call **Member Services** to find out if *your* plan has BlueCard Worldwide benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up to date health ID card with *you*.

When you are traveling abroad and need medical care

You can call the BlueCard WorldWide Service Center any time. They are available 24 hours a day, seven days a week. The toll free number is 800-810-2583. Or *you* can call them collect at 804-673-1177. An Assistance Coordinator will speak with *you* and help to set up an appointment with a doctor or *hospital*. The Assistance Coordinators will check with a medical professional, if needed, to determine the best course of action for *you*.

If *you* need *inpatient hospital* care, *you* or someone on *your* behalf, should contact *us* for preauthorization. Keep in mind, if *you* need *emergency* medical care, go to the nearest *hospital*. There is no need to call before *you* receive care.

Please refer to the "Requesting Approval for Benefits" paragraphs earlier in this section. *You* can learn how to get preauthorization when *you* need to be admitted to the *hospital* for *emergency* care.

How claims are paid with BlueCard Worldwide

In most cases, when *you* arrange care with BlueCard Worldwide and receive services from a BlueCard Worldwide participating *hospital*, claims will be filed for *you*. The only amounts that *you* may need to pay up front are any *copayment*, *coinsurance* or *deductible* amounts that may apply.

You will need to pay for the following services up front:

- Doctors' services;
- *Inpatient hospital* care not arranged through BlueCard Worldwide; and
- *Outpatient* services.

You will need to file a claim form for any payments made up front.

When you need BlueCard Worldwide claim forms

You can get international claims forms in the following ways:

- Call the BlueCard Worldwide Service Center at the numbers above; or
- Online at www.bcbs.com/bluecardworldwide.

You will find the address for mailing the claim on the form.

Out-of-Network Services

When *you* do not use an in-network *provider* or get care as part of an authorized service, *covered services* are covered at the out-of-network level, unless otherwise indicated in this *EOC*.

For services from an out-of-network *provider*:

1. The out-of-network *provider* can charge *you* the difference between their bill and the plan's *maximum allowed amount* plus any *deductible* and/or *coinsurance/copayments*;

2. *You* may have higher cost sharing amounts (i.e., *deductibles*, *coinsurance*, and/or *copayments*);

3. *You* will have to pay for services that are not *medically necessary*;

4. *You* will have to pay for non-*covered services*;

5. *You* may have to file claims; and

6. *You* must make sure any necessary precertification is done. (Please see "Requesting Approval for Benefits" for more details.)

Notification

HealthKeepers will participate in coordinating *your* care if *you* are hospitalized as a result of receiving *emergency* services. *You* or a representative on *your* behalf should notify *us* within 48 hours after *you* begin receiving care. **This applies to services received within or outside the *service area.***

Hospital Admissions

All non-*emergency hospital* admissions must be arranged by the *member's* admitting *HealthKeepers' physician* and approved in advance by *us,* except for maternity admissions as specified in the maternity section of this *EOC. We* also reserve the right to determine whether the continuation of any *hospital* admission is *medically necessary.* For *emergency* admissions, refer to the preceding paragraph **Notification.**

We will respond to a request for hospital admission within 2 working days after receiving all of the medical information needed to process the request, but not to exceed 15 days from the receipt of the request. *We* may extend this period for another 15 days if *we* determine it to be necessary because of matters beyond its control. In the event that this extension is necessary, *you* will be notified prior to the expiration of the initial 15-day period.

In cases where the *hospital* admission is an urgent care claim, a coverage decision will be completed within 24 hours. *Your* physician will be notified verbally of the coverage decision within this timeframe.

Once a coverage decision has been made regarding *your hospital* admission, *you* will receive written notification of the coverage decision. In the event of an *adverse benefit determination,* the written notification will include the following:

- information sufficient to identify the claim involved;
- the specific reason(s) and the plan provision(s) on which the determination is based;

- a description of any additional material or information necessary to reopen the claim for consideration, along with an explanation of why the requested material or information is needed;
- a description of the *our* appeal procedures and applicable time limits;
- in the case of an urgent care claim, a description of the expedited review process applicable to such claims; and
- the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist *you* with the internal or external appeals process.

If all or part of a *hospital* admission was not covered, *you* have a right to see, upon request and at no charge, any rule, guideline, protocol or criterion that the *we* relied upon in making the coverage decision. If a coverage decision was based on *medical necessity* or the *experimental* nature of the care, *you* are entitled to receive upon request, and at no charge, the explanation of the scientific or clinical basis for the decision as it relates to *your* medical condition.

Hospital admissions for covered radical or modified radical mastectomy shall be approved for a period of no less than 48 hours. *Hospital* admissions for a covered total or partial mastectomy with lymph node dissection for the treatment of breast cancer shall be approved for a period of no less than 24 hours. *Hospital* admissions for a covered laparoscopy-assisted vaginal hysterectomy shall be approved for a period of no less than 23 hours. *Hospital* admissions for a covered vaginal hysterectomy shall be approved for a period of no less than 48 hours.

The length of *stay* for maternity *hospital* admissions is determined according to Virginia insurance law. Virginia law does not specify any number of hours that must be approved for a maternity *stay.* However, it requires health insurers and *HealthKeepers* follow the guidelines and standards of the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in determining length of *stay.*

Out-of-Plan

You must initiate pre-admission authorization from *us* if *you* choose to receive *out-of-plan* care. This is necessary for all *out-of-plan* non-*emergency inpatient* admissions including admissions for *mental health and substance use disorder* conditions. If authorization is not received from *us, you* will be responsible for all costs (physician, non-physician, and *facility)* related to the *hospital stay.*

What is Covered

All *covered services* must be prescribed or performed by an appropriately licensed *provider* or *facility.* All benefits are subject to the terms, conditions, definitions, limitations, and exclusions described in this *EOC.* Only *medically necessary covered services* will be provided by *us.* If a service is not considered *medically necessary, you* will be responsible for the charges. *Additionally, we* will only pay the charges incurred by *you* when *you* are actually eligible for the *covered services* received (for example, the *premium* has been paid by *you* or on *your* behalf).

The following pages describe the benefits available to *you* under this *EOC.*

Allergy Services

Your benefits include *medically necessary* services for allergy testing and treatment, including allergy serum and allergy shots.

Ambulance Travel

Ambulance Services (Air, Ground and Water)

Medically Necessary ambulance services are a *covered service* when one or more of the following criteria are met:

- *You* are transported by a *state* licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, fixed wing, rotary wing or water transportation.
- *You* are taken:
  1) From *your* home, scene of accident or medical *emergency* to a *hospital*;
  2) Between *hospitals*, including when *we* require *you* to move from an out-of-network *hospital* to an in-network *hospital*; or
  3) Between a *hospital*, skilled nursing *facility* (ground transport only) or approved *facility*.

You must be taken to the nearest *facility* that can give care for *your* condition. In certain cases *we* may approve benefits for transportation to a *facility* that is not the nearest *facility*.

Benefits also include *medically necessary* treatment of a sickness or injury by medical professionals during an ambulance service, even if *you* are not taken to a *facility*.

Out-of-network *providers* may bill *you* for any charges that exceed the *EOC's maximum allowed amount*.

Ground Ambulance

Services are subject to *medical necessity* review by *us*. All scheduled ground ambulance services for non-*emergency* transports, not including acute *facility* to acute *facility* transport, must be preauthorized.

Air and Water Ambulance

Air ambulance services are subject to *medical necessity review* by *us*. *We* retain the right to select the air ambulance *provider*. This includes fixed wing, rotary wing or water transportation.

Air ambulance services for non-*emergency hospital* to *hospital* transports must be preauthorized.

Hospital to Hospital Air Ambulance Transport

Air ambulance transport is for purposes of transferring from one *hospital* to another *hospital* and is a *covered service* if such air ambulance transport is *medically necessary*, for example, if transportation by ground ambulance would endanger *your* health or the transferring *hospital* does not have adequate facilities to provide the medical services needed. Examples of such specialized medical services that are generally not available at all type of facilities may include but are not limited to: burn care, cardiac care,

trauma care, and critical care. Transport from one *hospital* to another *hospital* is covered only if the *hospital* to which the patient is transferred is the nearest one with *medically* appropriate facilities.

Fixed and Rotary Wing Air Ambulance

Fixed wing or rotary wing air ambulance is furnished when *your* medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by fixed wing or rotary wing air ambulance may be necessary because *your* condition requires rapid transport to a treatment *facility,* and either great distances or other obstacles preclude such rapid delivery to the nearest appropriate *facility*. Transport by fixed wing or rotary wing air ambulance may also be necessary because *you* are located in a place that is inaccessible to a ground or water ambulance *provider*.

Chiropractic Care

See the Spinal Manipulation and Manual Medical Therapy Services provision in this section.

Clinical Trials

Benefits include coverage for services, such as routine patient care costs, given to *you* as a participant in an approved *clinical trial* if the services are *covered services* under this *EOC*. An “approved *clinical trial*” means a phase I, phase II, phase III, or phase IV *clinical trial* that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
    a) The National Institutes of Health.
    b) The Centers for Disease Control and Prevention.
    c) The Agency for Health Care Research and Quality.
    d) The Centers for Medicare & Medicaid Services.
    e) Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
    f) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
    g) Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
        i. The Department of Veterans Affairs.
        ii. The Department of Defense.
        iii. The Department of Energy.
2. Studies or investigations done as part of an *investigational* new drug application reviewed by the Food and Drug Administration.
3. Studies or investigations done for drug trials which are exempt from the *investigational* new drug application.

Your EOC may require *you* to use an in-network *provider* to maximize *your* benefits.

Routine patient care costs include items, services, and drugs provided to *you* in connection with an approved *clinical trial* and that would otherwise be covered by this *EOC*.

When a requested service is part of an approved *clinical trial*, it is a *covered service* even though it might otherwise be *Investigational* as defined by this *EOC*. All other requests for *clinical trials* services that are not part of approved *clinical trials* will be reviewed according to our clinical coverage guidelines, related policies and procedures.

Your EOC is not required to provide benefits for the following services. *We* reserve *our* right to exclude any of the following services

i. The *investigational* item, device, or service, itself; or
ii. Items and services that are given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
iii. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
iv. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Dental Services - Accident Related and Covered General Anesthesia and Hospitalization

Benefits are available for *medically necessary* dental services resulting from an accidental dental injury, regardless of the date of such injury. For an injury that occurs on or after *your effective date* of coverage, *you* must seek treatment within 60 days after the injury. *You* must submit a plan of treatment from *your* dentist or oral surgeon for *our* approval for a dental injury. No approval of a plan of treatment is required by *us,* for *emergency* treatment of a dental injury.

Covered services include:

- the cost of dental services and dental appliances only when required to diagnose or treat an accidental injury to the teeth;
- the repair of dental appliances damaged as a result of an accidental injury to the jaw, mouth or face;
- dental services to prepare the mouth for radiation therapy to treat head and neck cancer; or
- covered general anesthesia and hospitalization services for children under the age of 5, *members* who are severely disabled, and *members* who have a medical condition that requires admission to a *hospital* or *outpatient* surgery *facility*. These services are only provided when it is determined by a licensed dentist, in consultation with the *member's* treating physician that such services are required to effectively and safely provide dental care. If the covered person meets the above requirements for an *inpatient* setting, *we* require *you* to contact *us* for admission review before the person receives the services. Please see the "How Your Coverage Works" section for important details on meeting *our* admission review requirements.

Helpful tip: *We* provide coverage only for functional repairs. Services of a cosmetic nature, or not deemed to be functional by *us,* are not *covered services.*

Covered Dental Care for Pediatric Members

All *covered services* are subject to the terms, limitations, and exclusions of *your EOC*. See *your* **Schedule of Cost Shares and Benefits** for *your cost share* amounts, such as *deductibles* and/or any *coinsurance.*

Your Dental Benefits

We do not determine whether the dental services listed in this section are *medically necessary* to treat *your* specific condition or restore *your* dentition. There is a preset schedule of dental care services that are a *covered service* under this *EOC*. *We* evaluate the procedures submitted to *us* on *your* claim to determine if they are a *covered service* under this *EOC*.

Exception: Claims for orthodontic care will be reviewed to determine if it was dentally necessary orthodontic care. See the section "Orthodontic Care" for more information.

Your dentist may recommend or prescribe other dental care services that are not covered, are cosmetic in nature, or exceed the benefit frequencies of this *EOC*. While these services may be necessary for *your* dental condition, they may not be covered by *us*. There may be an alternative dental care service available to *you* that is covered under *your EOC*. These alternative services are called optional treatments. If an allowance for an optional treatment is available, *you* may apply this allowance to the initial dental care service prescribed by *your* dentist. *You* are responsible for any costs that exceed the allowance, in addition to any *coinsurance* or *deductible you* may have.

The decision as to what dental care treatment is best for *you* is solely between *you* and *your* dentist.

Pretreatment Estimates

A pretreatment estimate is a valuable tool for *you* and *your* dentist. It provides *you* and the dentist with an idea of what *your* out of pocket costs will be for the dental care treatment. This will allow the dentist and *you* to make any necessary financial arrangements before treatment begins. It is a good idea to get a pretreatment estimate for dental care that involves major restorative, periodontic, prosthodontic, endodontic, oral surgery, or orthodontic care.

The pretreatment estimate is recommended, but it is not required for *you* to receive benefits for covered dental care services.

A pretreatment estimate does not authorize treatment or determine its *medical necessity* (except for orthodontics), and does not guarantee benefits. The estimate will be based on *your* current eligibility and the benefits in effect at the time the estimate is submitted to *us*. This is an estimate only. *Our* final payment will be based on the claim that is submitted at the time of the completed dental care service(s). Submission of other claims, changes in *your* eligibility or changes to the *EOC* may affect *our* final payment.

You can ask *your* dentist to submit a pretreatment estimate for *you*, or *you* can send it to *us* yourself. Please include the procedure codes for the services to be performed (*your* dentist can tell *you* what procedures codes). Pretreatment estimate requests can be sent to the address on *your* dental ID card.

Dental Providers

You do not have to select a particular dentist to receive dental benefits. *You* can choose any dentist *you* want for *your* dental care. However, *your* dentist choice can make a difference in what benefits are covered and how much *you* will pay out-of-pocket. *You* may have more out-of-pocket costs if *you* use a dentist that is an out-of-network dentist. There may be differences in the amount *we* pay between an in-network dentist and an out-of-network dentist.

Please call the **Member Services** number on *your* ID card for help in finding an in-network dentist or visit our website at www.anthem.com/mydentalvision. Please refer to *your* ID card for the name of the dental program that in-network providers have agreed to service when *you* are choosing an in-network dentist.

Description of Covered Services for Pediatric Members

***We* cover the following dental care services for *members* to the end of the month in which they turn age 19,** when they are performed by a licensed dentist, and when necessary and customary as determined by the standards of generally accepted dental practice. If there is more than one professionally acceptable treatment for *your* dental condition, *we* will cover the least expensive.

Diagnostic and Preventive Services

Oral Evaluations - Covered once per 6 months, beginning with the eruption of the first tooth. The following types of oral exams covered are:

- Periodic
- Limited – problem focused
- Oral exam under 3 years of age
- Comprehensive

Radiographs (X-rays)

- Bitewings - covered at 1 series of bitewings per year.
- Full Mouth (Complete Series) - covered 1 time per 60 month period.
- Panoramic – covered 1 time per 60-month period.
- Periapical(s) and extraorals - covered as needed per diagnosis.
- Occlusal – 2 per 12 month period.

Dental Cleaning (Prophylaxis) –Covered once every 6 months. Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.

Fluoride Treatment (Topical application **or Fluoride Varnish** - Covered once every 6 months.

Sealants – Covered once per tooth per lifetime for permanent first and second molars. Sealants will not be covered if placed over restorations or if tooth has existing caries (decay).

Space Maintainers (fixed unilateral, fixed bilateral, removable unilateral) – Covered once per calendar year.

Limitation: Repair or replacement of lost/broken appliances is not a covered benefit.

Recementation of Space Maintainer

Removal of Fixed Space Maintainer. Covered only when performed by dentist or dental office that did not initially place the space maintainer.

Other Adjunctive Diagnostic and Preventive Services

- Therapeutic drug injections, by report
- Drugs or medicaments, by report
- Treatment of complications (post surgical), by report

Basic Restorative Services

Consultations

Fillings (restorations). A filling is a treatment to restore decayed or fractured teeth. There are two types of fillings: amalgam (silver) or composite (tooth colored).

- Amalgam (silver) fillings: covered for permanent and primary posterior (back) teeth. Treatment to restore decayed or fractured permanent or primary posterior (back) teeth.
- Composite (white) fillings: covered for permanent and primary anterior (front) teeth. If *you* get a composite restoration on a posterior (back) tooth, it is considered an optional treatment and will be covered up to the *maximum allowed amount* for an amalgam filing. *You* will be responsible to pay the difference between the *maximum allowed amount* and the dentist's actual charge. This is in addition to any applicable *coinsurance*.

Limitation: Fillings are covered once per tooth per surface per a 12 month period.

Endodontic Services

Pulpotomies. Covered once per tooth per lifetime. Will not be covered if billed with root canal therapy.

Pulp cap (direct or indirect). Covered once per tooth per lifetime.

Gross pulpal debridement (primary and permanent teeth)

Pulpal therapy. Covered once per tooth per lifetime.

Root Canal Therapy. Covered once per tooth per lifetime.

Retreatment of previous root canal. Covered once per tooth per lifetime.

Apexification. Initial *visit*, interim medication replacement (limited to 3 treatments) and final *visit* once per tooth per lifetime.

Pulpal Regeneration. Limited to once per tooth per lifetime.

Apicoectomy/Periradicular Surgery. Limited 1 per lifetime per tooth.

Retrograde filling. Limited to 1 per lifetime per tooth.

Gingivectomy or gingivoplasty. Covered once per 24 months per quadrant.

Periodontal Services

Periodontal scaling & root planning. Covered once per 24 month per quadrant.

Emergency room services provided by a dentist. Only covers occlusal orthotic devices.

Crown lengthening. Covered once per tooth per lifetime.

Full Mouth Debridement. Covered once per 12 months.

Osseous Surgery. Covered once per 60 months per quadrant.

Provisional Splinting.

Oral Surgery Services

Basic Extractions

- Removal of coronal remnants (retained pieces of the crown portion of the tooth) on primary teeth
- Extraction of erupted tooth or exposed root

Complex Surgical Extractions

- Surgical removal of erupted tooth
- Surgical removal of impacted tooth
- Surgical removal of residual tooth roots

Limitation: Surgical removal of 3rd molars is only covered if the removal is associated with symptoms or oral pathology.

Other Oral Surgery Procedures.

- Incision and drainage of abscess (intraoral soft tissue)
- Biopsy of oral tissue

Tooth Reimplantation and/or stabilization of accidentally evulsed or displaced tooth - Covered only when medically necessary.

Adjunctive General Services

- Intravenous and Non-Intravenous Conscious Sedation and General Anesthesia – Covered only when given with covered oral surgery services by a dentist or by an employee of the dentist when the service is performed in his or her office who is certified in their profession to provide anesthesia services. Covered up to a maximum of 150 minutes (10 units).

Major Restorative Services

Pre-fabricated or Stainless Steel Crown or Temporary Crown. Covered as needed per pathology. Temporary crown not covered if used during crown fabrication.

Protective Restorations. Not covered when given with root canal therapy, pulpotomy, pulpectomy or on the same date of service as another restoration.

Permanent Crowns (high noble metal, porcelain only, or metal/porcelain). Covered one time per 60 month period if the tooth has extensive loss of natural tooth structure due to decay or tooth fracture such that a restoration cannot be used to restore the tooth. Covered for permanent teeth only.

Labial Veneers. Covered one per 60 months per tooth. Considered as an alternative to a full restoration for an endodontically treated tooth.

Occlusal Guards, by report

Prosthodontic Services

Removable Prosthetic Services (Dentures and Partials) - Covered 1 time per 60 month period:

- For the replacement of extracted (removed) permanent teeth;
- If 60 months have elapsed since the last covered removable prosthetic appliance (denture or partial) and the existing denture or partial cannot be repaired or adjusted.
- Immediate dentures are covered 1 time per lifetime.

Fixed Prosthetic Services (Bridge) - Covered 1 time per 60 month period:

- For the replacement of extracted (removed) permanent teeth;
- If no more than 3 teeth are missing in the same arch;
- A natural, healthy, sound tooth is present to serve as the anterior and posterior retainer;
- No other missing teeth in the same arch that have not been replaced with a removable partial denture;
- If none of the individual units of the bridge has been covered previously as a crown or cast restoration in the last 60 months;
- If 60 months have elapsed since the last covered removable prosthetic appliance (bridge) and the existing bridge cannot be repaired or adjusted.

Limitation: If there are multiple missing teeth, a removable partial denture may be the benefit since it would be the least costly, commonly performed course of treatment. The optional benefit is subject to all *EOC* limitations on the *covered service*.

Denture adjustments. Not covered within 6 months of placement.

Denture or bridge repair

Reline denture (chair or laboratory). Covered once per 24 month period. Not covered within 6 months of placement.

Tissue Conditioning

Recement Fixed Partial Denture

Orthodontic Treatment

Orthodontic treatment is the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. *You* should submit *your* treatment plan to *us* before *you* start any orthodontic treatment to make sure it is covered under this *EOC*.

Dentally Necessary Orthodontic Care

We will only cover orthodontic care that is *dentally necessary orthodontic care*. To be considered dentally necessary orthodontic care at least one of the following criteria must be present:

a) There is spacing between adjacent teeth which interferes with the biting function;

b) There is an overbite to the extent that the lower anterior teeth impinge on the roof of the mouth when *you* bite;
c) Positioning of the jaws or teeth impair chewing or biting function;
d) On an objective professionally recognized dental orthodontic severity index, the condition scores at a level consistent with the need for orthodontic care; or
e) Based on a comparable assessment of items a through d, there is an overall orthodontic problem that interferes with the biting function.

Orthodontic treatment may include the following:

- Limited Treatment - Treatments which are not full treatment cases and are usually done for minor tooth movement.
- Interceptive Treatment - A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment.
- Comprehensive (complete) Treatment - Full treatment includes all radiographs, diagnostic casts/models, appliances and *visits.*
- Removable Appliance Therapy - An appliance that is removable and not cemented or bonded to the teeth.
- Fixed Appliance Therapy - A component that is cemented or bonded to the teeth.
- Complex Surgical Procedures – Surgical exposure of impacted or unerupted tooth for orthodontic reasons; or surgical repositioning of teeth.

Note: Treatment in progress (appliances placed prior to being covered under this *EOC*) will be benefited on a pro-rated basis.

Benefits do not include:

- Monthly treatment *visits* that are inclusive of treatment cost;
- Repair or replacement of lost/broken/stolen appliances;
- Orthodontic retention/retainer as a separate service;
- Retreatment and/or services for any treatment due to relapse;
- *Inpatient* or *outpatient hospital* expenses (please refer to *your* medical coverage to determine if this is a covered medical service); and
- Temporary procedures.

Orthodontic Payments

Because orthodontic treatment normally occurs over a long period of time, payments are made over the course of *your* treatment. *You* must have continuous coverage under this *EOC* in order to receive ongoing payments for *your* orthodontic treatment.

Payments for treatment are made: (1) when treatment begins (appliances are installed), and (2) at six month intervals thereafter, until treatment is completed or this coverage ends.

Before treatment begins, the treating dentist should submit a pre-treatment estimate to *us*. An Estimate of Benefits form will be sent to *you* and *your* dentist indicating the estimated *maximum allowed amount*, including any amount (*coinsurance*) *you* may owe. This form serves as a claim form when treatment begins.

When treatment begins, the dentist should submit the Estimate of Benefit form with the date of appliance placement and his/her signature. After benefit and eligibility verification by *us*, a payment will be issued. A new/revised Estimate of Benefits form will also be issued to *you* and *your* dentist. This again will serve as the claim form to be submitted 6 months from the date of appliance placement.

Devices and Supplies for Sleep Treatment

Your EOC includes coverage for devices and supplies, such as APAP, CPAP, BPAP and oral devices for sleep treatment. These services are subject to *medical necessity* reviews by *us*.

Diabetic Supplies, Equipment, and Education

Your coverage provides for medical supplies, equipment, and education for diabetes care for all diabetics. This includes, but not limited to coverage for the following:

- insulin pumps;
- home blood glucose monitors, lancets, blood glucose test strips, syringes and hypodermic needles and syringes when received from a *HealthKeepers pharmacy*;
- *outpatient* self-management training and education performed in-person, including medical nutrition therapy, when provided by a certified, licensed, or registered health care professional; and
- foot care to minimize the risk of infection (treatment of corns, calluses, and care of toenails).

Diabetic training and education may be rendered by a licensed pharmacist who is authorized by the treating physician to perform this service. To determine whether or not a licensed pharmacist is authorized to perform this service, *you* may ask the licensed pharmacist.

Diagnostic Services

Your EOC includes benefits for tests or procedures to find or check a condition when specific symptoms exist, as well as benefits for interpretation of diagnostic tests such as imaging, pathology reports, and cardiology. Tests must be ordered by a *provider* and include diagnostic services ordered before a surgery or *hospital* admission. Benefits include the following services:

Diagnostic Laboratory and Pathology Services

Diagnostic Sleep Testing

Diagnostic Imaging Services and Electronic Diagnostic Tests

- X-rays / regular imaging services
- Radiology (including mammograms), or nuclear medicine
- Ultrasound
- Electrocardiograms (EKG)
- Electroencephalography (EEG)
- Echocardiograms
- Hearing and vision tests for a medical condition or injury (not for screenings or preventive care)
- Tests ordered before a surgery or admission.

Advanced Imaging Services

Benefits are also available for advanced imaging services, which include but are not limited to:

- CT scan
- CTA scan
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)
- Magnetic Resonance Spectroscopy (MRS)

- Nuclear Cardiology
- PET scans
- PET/CT Fusion scans
- QTC Bone Densitometry
- Diagnostic CT Colonography

The list of advanced imaging services may change as medical technologies change.

Dialysis

Your coverage provides for dialysis treatment, including hemodialysis and peritoneal dialysis. These are treatments of severe kidney failure or chronic poor functioning of the kidneys. *Covered services* include dialysis treatments in an *outpatient* dialysis *facility* or doctor's office. *Covered services* also include home dialysis treatment, equipment and supplies.

Doctor Visits and Services

Your EOC covers care provided by *primary care physicians* and *specialty care physicians*. To see a *primary care physician* (*PCP*), simply visit any physician who is a general or family practitioner, internist, or pediatrician. *Your EOC* also covers care provided by *specialty care provider* (*SCP*). *Specialty care providers* are any covered providers, other than the *primary care physicians* listed above. *Referrals* are never needed to visit a *specialty care provider*.

Your coverage provides for:

- *visits* to a doctor's office or *your* doctor's *visits* to *your* home;
- *visits* to an urgent care center;
- *visits* to a *retail health clinic*;
- *visits* to an ambulatory surgery center;
- doctor *visits* in a *hospital outpatient* department or *emergency* room;
- doctor *visits* in an *inpatient hospital* setting;
- *visits* for shots needed for treatment (for example, allergy shots); and
- interactive *telemedicine services.*

Online Visits

When available in *your* area, *your* coverage will include online *visit* services. *Covered services* include a medical *visit* with the doctor using the internet by a webcam, chat or voice. Online *visits* do not include reporting normal lab or other test results, requesting office *visits*, getting answers to billing, insurance coverage or payment questions, asking for *referrals* to doctors outside the online care panel, benefit precertification, or doctor to doctor discussions.

Early Intervention Services

Your coverage includes benefits for early intervention services for covered *dependents* from birth to age three who are certified by the Department of Behavioral Health and Developmental Services ("the Department") as eligible for services under Part C of the Individuals with Disabilities Education Act. These services consist of:

- speech and language therapy;

- occupational therapy;
- physical therapy; and
- assistive technology services and devices.

Early intervention services for the population certified by the Department are those services listed above which are determined to be *medically necessary* by the Department and designed to help an individual attain or retain the capability to function age-appropriately within his environment. This shall include services which enhance functional ability without effecting a cure. Benefits for services listed shall not be limited by the exclusion of services that are not *medically necessary*. *Your deductible*, *copayments* or *coinsurance* amounts for these services may be paid through Federal, *state* or local funds. A *provider* must perform the covered therapies listed above.

Emergency Room Care

Emergency room care services are those *covered services*, which are rendered by in-network or out-of-network *providers* for the sudden onset of an *emergency* condition. *Your* benefits include coverage for *emergency* room visits, other services, and supplies necessary for the treatment of an *emergency* condition, as defined in this *EOC*.

Emergency room care includes a medical exam done in the *emergency* department of a *hospital*, and includes services routinely available to evaluate and treat an *emergency* condition and/or services to initially screen and *stabilize* the patient.

Such conditions include, but are not limited to, chest pain, heart attacks, stroke, poisoning, serious breathing problems, unconsciousness, severe burns or cuts, uncontrolled bleeding, or seizures and such other acute conditions, as may be determined by *us* to be *emergencies*.

If *you* are experiencing an *emergency* please call 911 or visit the nearest *hospita*l for treatment.

Habilitative Services

Your coverage includes benefits for *habilitative services* that help *you* keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of *inpatient* and/or *outpatient* settings.

Hemophilia and Congenital Bleeding Disorders

Your coverage includes benefits for hemophilia and congenital bleeding disorders. *We* cover expenses incurred in connection with the treatment of routine bleeding episodes associated with hemophilia and other congenital bleeding disorders. Coverage includes the purchase of blood products and blood infusion equipment required for home treatment of routine bleeding episodes associated with hemophilia and other congenital bleeding disorders when the home treatment program is under the supervision of the *state*-approved hemophilia treatment center.

Home Care Services

When authorized by *us, we* cover treatment provided in *your* home on a part-time or intermittent basis. This coverage allows for an alternative to repeated hospitalizations that will provide the quality and appropriate level of care to treat *your* condition. To ensure benefits, *your* doctor must provide a description of the treatment *you* will receive at home. *Your* coverage includes the following home health services:

- *visits* by a licensed health care professional, including nursing services by an R.N. or L.P.N, a therapist, or home health aide; and

- physical, speech, and occupational therapy (services provided as part of home health are not subject to separate *visit* limits for therapy services).

These services are only covered when *your* condition generally confines *you* to *your* home at all times except for brief absences.

Hospice Care Services

Hospice Care

Hospice care is a coordinated plan of home, *inpatient* and/or *outpatient* care that provides palliative, supportive medical, psychological, psychosocial, and other health services to terminally ill patients. *Services* and supplies listed below are covered, if part of an approved treatment plan and when rendered by a hospice *provider* for the palliative treatment of pain and other symptoms associated with a terminal disease. Palliative care means appropriate care which controls pain and relieves symptoms, but is not meant to cure a terminal illness. Please refer to the **Schedule of Cost Shares and Benefits** for details on the payment levels and limits for services and supplies listed below. *You* should also refer to the Exclusions section for services that are not covered.

- Care rendered by an Interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term *inpatient facility* care when required in periods of crisis or as respite care.
- Skilled nursing services, home health aide services or homemaker, provided by or under the supervision of a registered nurse.
- Social services and counseling services provided by a licensed social worker.
- Nutritional support such as intravenous hydration and feeding tubes.
- Physical therapy, occupational therapy, speech therapy and respiratory therapy.
- Pharmaceuticals, *medical equipment* and supplies necessary for the palliative treatment of *your* condition including oxygen and related respiratory therapy supplies.

In order to receive hospice benefits (1) *your* physician and the hospice medical director must certify that *you* are terminally ill and generally have less than six months to live, and (2) *your* physician must consent to *your* care by the hospice and must be consulted in the development of your treatment plan. The hospice must maintain a written treatment plan on file and furnish to *us* upon request.

Additional *covered services* to those listed above (such as chemotherapy and radiation therapy) when provided for palliation of the effects of a terminal illness are available while in hospice. Benefits for these additional *covered services*, which are described in other parts of this certificate, are provided as set forth in other parts of this certificate.

Hospital Services

Your coverage provides benefits for the *hospital* and doctors' services when *you* are treated on an *outpatient* basis, or when *you* are an *inpatient* because of illness, injury, or pregnancy. (See **Maternity** in this section for an additional discussion of pregnancy benefits.) *Your* benefits include coverage for *medically necessary* care in a semi-private room or intensive or special care unit. This includes *your* bed, meals, special diets, and general nursing services.

In addition to *your* semi-private room, general nursing services and meals, *your* coverage includes *maximum allowed amounts* for *medically necessary* services and supplies furnished by the *hospital* when prescribed by *HealthKeepers' physicians.*

While *you* are an *inpatient* in the *hospital*, *you* have coverage for the *medically necessary* services rendered by *HealthKeepers' physicians* and other *HealthKeepers' providers.*

Helpful tip: All non-*emergency inpatient hospital stays* must be approved in advance, except *hospital stays* for vaginal or cesarean deliveries without complications.

Private room
Your inpatient hospital benefits include a *stay* in a semi-private room unless a private room is approved in advance by *HealthKeepers*. *We* will cover the private room charge if *you* need a private room because *you* have a highly contagious condition or are at greater risk of contracting an infectious disease because of *your* medical condition. Otherwise, *your inpatient* benefits will cover the *hospital's* charges for a semi-private room. If *you* choose to occupy a private room, *you* will be responsible for paying the daily differences between the semi-private and private room rates in addition to *your copayment* and *coinsurance* (if any).

- a ward bed (if a semi-private room is not available). *Your maximum allowed amount* for a ward bed will not be more than the *hospital's* charge for its semi-private rooms. If a ward or semi-private room is not available, you will be responsible for paying the daily differences between the semi-private and private room rates in addition to *your copayment* and *coinsurance* (if any); or
- a bed in an intensive care unit. If a *hospital* charges for both bed and board and an intensive care unit on the same day, *your allowable charge* will be the *hospital's* most common charge for the intensive care unit only.

Length of Stay Requirements:

- *Hospital* admissions for covered radical or modified radical mastectomy for the *treatment* of breast cancer shall be authorized for a period of no less than 48 hours. *Hospital* admissions for covered total mastectomy or partial mastectomy with lymph node dissection for the *treatment* of breast cancer shall be authorized for a period of no less than 24 hours; and

- *We* provide coverage for a minimum *stay* in the *hospital* for a period of no less than 23 hours for a covered laparoscopy-assisted vaginal hysterectomy. *Hospital* admissions for a covered vaginal hysterectomy shall be provided for a period of no less than 48 hours.

  The total hours referenced is not required when the attending physician in consultation with the patient determines that a shorter period of *hospital stay* is appropriate.

Ancillary Services

"Ancillary services" are those services rendered to an *inpatient*, other than bed, board and general nursing, as long as there is a reasonable relationship between the patient's diagnosis and the care rendered.

Ancillary services coverage means these *hospital* services and supplies:

- operating, recovery, or treatment room services;
- medications, injectable drugs, solutions, and biological preparations used in the hospital;
- oxygen, oxygen tent, and inhalation therapy;
- dressings and plaster casts;
- laboratory services;
- anesthesia services and supplies;
- diagnostic tests;
- physical therapy;
- pathology exams;
- blood and blood products;

- administration of infusion therapy and transfusions of blood. This includes professional donor fees;
- nuclear medicine and radiological services;
- emergency room services leading directly to admission or given to a covered person who died before admission;
- speech and hearing therapy;
- chemotherapy;
- dialysis in conjunction with renal failure;
- occupational therapy to restore your independent performance of activities of daily living and;
- ambulance services for travel between local hospitals when:
    - the *hospital* where *you* are an *inpatient* cannot provide the *hospital* service *you* need; and
    - *your* condition precludes the use of any other less – expensive way to travel.

LIMITATION: *We* do not cover any therapy that has as its main purpose *your* vocational rehabilitation or job training.

Tier 1 and Tier 2 *Hospitals*

We have designated certain *hospitals* as participating in Tier 1 or Tier 2. *Tier 1 hospitals* have lower costs to the *member*. *Tier 2 hospitals* are more costly. While these *hospitals* are contracted with *us*, *we* make no representation on the relative quality of the services. When a *member* goes to an out-of-network *hospital*, there is no agreement on the cost of the service and the *member* is responsible for the amounts above the *maximum allowed amount* and for separate out-of-network *cost-shares*.

Below are examples of what criteria's are used to determine whether a *hospital* was allocated to Tier 1 or Tier 2. In communities where there was only one *hospital*, these *hospital*s were allocated to Tier 1:

- Total share of payments by region of the Commonwealth
- The number of admissions per *hospital* and region
- The average length of *stay* per *hospital*
- The percentage of admissions over *our* contractual threshold
- The current case mix adjusted case rate by *hospital* and by region.
- The effective *hospital* discount inclusive of patient pay
- The percentage of claims paid on stop loss by *hospital* and *hospital* system
- The average charge increase by *hospital* and *hospital* system
- The *hospital* efficiency ratio based on Virginia Health Information reported actual length of *stay* divided by expected length of *stay*.

Outpatient Hospital Services
These are services provided in the *hospital's outpatient* department, freestanding ambulatory surgical facility, or *hospital's emergency* room.

We cover *medically necessary* care related to:

- services and supplies used to diagnose or treat injuries resulting from an accident (including follow-up care);
- services and supplies used to diagnose or treat the sudden onset of a severe *emergency* medical condition; and
- services and supplies related to, and provided at the same time as a covered *outpatient* surgical services.

Examples include:

- anesthesia and its related supplies;

- surgical rooms and equipment;
- medical and surgical dressings and supplies (including hypodermic needles and syringes), casts, and splints,
- blood and blood products;
- diagnostic services;
- therapy services; and
- operating and recovery room use.

Outpatient Care for an Inpatient from another Hospital
The ancillary services listed under the *inpatient hospital services* provision of this section are covered at a different *hospital* location if the *facility* where you are an *inpatient* cannot provide the *medically necessary* service *you* need.

Infertility Services

Covered services include diagnostic tests to find the cause of infertility, such as diagnostic laparoscopy, endometrial biopsy, and semen analysis. Benefits also include services to treat the underlying medical conditions that cause infertility (e.g., endometriosis, obstructed fallopian tubes, and hormone deficiency).

Covered services do not include assisted reproductive technologies (ART) or the diagnostic tests and *drugs* to support it. Examples of ART include artificial insemination, in-vitro fertilization, zygote intrafallopian transfer (ZIFT), or gamete intrafallopian transfer (GIFT).

Infusion Services

When authorized by us, we cover infusion therapy, which is treatment by placing therapeutic agents into the vein, and parenteral administration of medication and nutrients. Infusion services also include enteral nutrition, which is the delivery of nutrients by tube into the gastrointestinal tract. These services include coverage of all prescription medications administered intravenously and/or parenterally. See the provision under "Prescription Drugs Administered by a Medical Provider" for more details.

Helpful tip: Infusion services may be received at multiple sites of service, including *inpatient* and *outpatient facilities*, professional *provider* offices, ambulatory infusion centers and from home infusion *providers*. Benefits may vary by place of service, and where *you* choose to receive *covered services* may result in a difference in *your copayment* and/or *coinsurance*. Please see the Infusion services section on the **Schedule of Cost Shares and Benefits** for a description of the benefits by place of service**.**

Injectable Medications

Your coverage includes benefits for self-administered injectable medications obtained through a retail *pharmacy* or administered by a *HealthKeepers' provider.*

Your EOC covers therapeutic injections (shots) that a *provider* gives or self-administered injections when prescribed by your physician, to treat illness or pregnancy-related conditions (e.g., allergy shots).

Some immunizations may be administered by a licensed pharmacist who is authorized by a physician to perform this service. To determine whether or not a licensed pharmacist is authorized to perform this service, *you* may ask the licensed pharmacist.

Joint (TMJ) and Craniomandibular Joint Services

Your benefits include services to treat temporomandibular and craniomandibular disorders. The temporomandibular joint connects the lower jaw to the temporal bone at the side of the head and the craniomandibular joint involves the head and neck muscles.

Covered services include removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services. *Covered services* do not include fixed or removable appliances that involve movement or repositioning of the teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures).

Lymphedema

Your coverage includes benefits for expenses incurred in connection with the treatment of lymphedema, including benefits for equipment, supplies, complex decongestive therapy, and *outpatient* self-management training and education.

Maternity Prenatal and Newborn Care

If *you* become pregnant, *your EOC* provides several coverage features. Maternity care, maternity-related checkups, and delivery of the baby in the *hospital* are covered. This benefit includes coverage for female *dependent* children.

Your Benefits Include:

- Pregnancy testing;
- preterm births;
- *hospital* bed and board for mother and newborn;
- home setting covered with nurse midwives;
- anesthesia services to provide partial or complete loss of sensation before and during delivery;
- *hospital* services and supplies for routine nursery care for the newborn during the mother's normal *hospital stay;*
- routine newborn physician services and screenings rendered in newborn nursery;
- prenatal and postnatal care services for pregnancy and complications of pregnancy for which hospitalization is necessary;
- *home care services* for postnatal care;*
- circumcision of a covered male *dependent*;
- use of the delivery room and care for newborn deliveries;
- diagnostic laboratory and x-rays;
- fetal screenings, which are tests for the genetic and/or chromosomal status of the fetus. The term also means anatomical, biochemical or biophysical tests, to better define the likelihood of genetic and/or chromosomal anomalies; and
- abortions in the case of rape or incest, or for a pregnancy which, as certified by a physician, places the woman in danger of death unless an abortion is performed (i.e., abortions for which federal funding is allowed).

*Please see the *home care services* provision above for details concerning home *visits*.

Your maternity benefits include *inpatient* care and a home *visit* or *visits* in accordance with the guidelines and standards of the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists.

Medical Equipment (Durable)

We cover the rental (or purchase if that would be less expensive) of *medical equipment (durable)* when prescribed by *your* physician and obtained from a *HealthKeepers' medical equipment (durable) provider*. Also covered are maintenance and necessary repairs of *medical equipment (durable)* except when damage is due to neglect. Durable *medical equipment* is an item which is primarily used to serve a medical purpose and can withstand repeated use. Durable *medical equipment* is generally not useful to a person in the absence of illness, injury or disease.

Examples of covered *medical equipment (durable)* include:

- nebulizers;
- *hospital* type beds;
- wheelchairs;
- traction equipment;
- walkers; and
- crutches.

Medical Devices and Appliances

We cover the following items, including the cost of fitting, adjustment, and repair when prescribed for *activities of daily living:*

Examples of covered medical devices include:

- orthopedic braces;
- leg braces, including attached or built-up shoes attached to the leg brace;
- molded, therapeutic shoes for diabetics with peripheral vascular disease;
- arm braces, back braces, and neck braces;
- head halters;
- catheters and related supplies;
- orthotics, other than foot orthotics; and
- splints.

Medical Formulas

We cover special medical formulas which are the primary source of nutrition for *members* with inborn errors of amino acid or organic acid metabolism, metabolic abnormality or severe protein or soy allergies. These formulas must be prescribed by a physician and required to maintain adequate nutritional status.

Medical Services

When *we* say "medical services" *we* mean professional services rendered by a *provider* for the *treatment* of an illness or an injury.

The term medical services does not include:

- surgical services;
- maternity services;
- anesthesia services;
- mental health services;
- diagnostic services;
- therapy services; and
- services not in accordance with national standards of good medical practice in the United States.

Please note that all of the specifically-named services above are described as *covered services* in other parts of this section.

Medical Services – Inpatient

We cover these medical services *you* receive from a *provider* when *you* are an *inpatient* in a *facility*:

- medical *visits* needed to diagnose or treat an illness or an injury;
- intensive medical services, when *your* medical condition requires a *provider's* constant attendance and treatment for a long period of time;
- medical services by one or more *providers*. The nature or severity of *your* medical condition must be such that another *provider's* skill is required; and
- consultation by a *provider* other than the attending physician.

Medical Services – Office/Outpatient

We cover medical services (including consultations) *you* receive from a *provider* in the *provider's* office, in *your* home, or in a covered *outpatient* setting.

These services are:

- medical *visits* needed to diagnose or treat an illness or injury;
- medical services needed to diagnose or treat the sudden onset of a severe *emergency* medical condition;
- *emergency care*; and
- medication management *visits*. A "medication management *visit*" is a *visit* no longer than 20 minutes with a *provider*, who has prescriptive authority, for the sole purpose of monitoring and adjusting medications prescribed for a mental health condition.

Medical Supplies and Medications

Your coverage includes benefits for medical supplies and medications. Examples of medical supplies include:

- hypodermic needles and syringes;
- allergy serum;
- oxygen and equipment (respirators) for its administration;

- sterile dressings;
- catheters;
- colostomy bags and related medical supplies;
- oxygen and equipment for its administration;
- cochlear implants;
- medical supplies, devices or equipment such as syringes, hypodermic needles, or prescription support stockings;
- glucometers for diabetics and gestational diabetics;
- injectable *prescription drugs* when administered by the *provider* in his office or in a covered *outpatient* setting;
- immunization agents;
- allergy sera;
- blood or blood plasma and blood derivates for hemophilia; and
- a one-time dose to treat an acute situation. *We* do not cover the daily or intermittent dosing of an oral *prescription drug* for an ongoing condition when administered by the *provider*, at the *provider's* office or in a covered *outpatient* setting.

Please discuss the cost of any medical supply, including injectable *drugs*, with your *provider*. Some supplies are more cost-effective than others.

Mental Health or Substance Use Disorder Treatment

Accessing *your mental health services and substance use disorder services* (treatment of alcohol or *drug* dependency) is easy. In fact, *you* have a dedicated department available to *you* simply by calling 1-800-991-6045. *You* can select any mental health and substance use disorder *provider* listed in *your HealthKeepers' provider* directory. Or if *you* are unsure of which *provider* to see, call 1-800-991-6045 and the representative will be able to match *you* with a *provider* who seems best suited to meet *your* needs.

Covered services include the following:

- *Inpatient* services in a *hospital* or any *facility* that *we* must cover per *state* law. *Inpatient* benefits include individual and group psychotherapy, psychological testing, electroconvulsive therapy, and detoxification.
- *Outpatient* services including office *visits* and treatment in an *outpatient* department of a *hospital* or *outpatient facility*, such as individual and group psychotherapy, psychological testing, partial hospitalization programs and intensive *outpatient* programs.
- Residential treatment which is specialized 24-hour treatment in a licensed residential treatment Center. It offers individualized and intensive treatment and includes:
    - Observation and assessment by a psychiatrist weekly or more often
    - Rehabilitation, therapy, and education.

You can get *covered services* from the following *providers*:

- Psychiatrist,
- Psychologist,
- Licensed clinical social worker (L.C.S.W.),
- Mental health clinical nurse specialist,

- Licensed marriage and family therapist (L.M.F.T.),
- Licensed professional counselor (L.P.C), or
- Any agency licensed by the *state* to give these services, when *we* have to cover them by law.

Medication Management

Visits to *your HealthKeepers' physician* to make sure that medication *you* are taking for a mental health or substance use disorder problem is working and the dosage is right for *you* are covered.

Obstetrician-Gynecologist Physician Services

All female *members* may receive services from an obstetrician-gynecologist or a certified nurse midwife who is a *HealthKeepers' provider* for the care of or related to the female reproductive system and breasts. The obstetrician-gynecologist must obtain authorization from *us* for *inpatient hospital* services, except *hospital stays* for vaginal or cesarean deliveries without complications and *outpatient* surgery.

Newborn Services

In addition to the services described in this section, *we* cover:

- *medically necessary* care and treatment of medically diagnosed congenital defects and birth abnormalities for covered newborns; and
- *inpatient* and *outpatient* dental, oral surgical, and orthodontic services which are *medically necessary* for the treatment of medically diagnosed cleft lip, cleft palate or ectodermal dysplasia for covered newborns.

Prescription Drugs

What You Pay for Prescription Drugs

Tier One, Tier Two, Tier Three, Tier Four

Your copayment/coinsurance amount may vary based on whether the *prescription drug*, including covered *specialty drugs*, has been classified by *us* as a first, second, third or fourth "tier" *drug*. Refer to *your* **Schedule of Cost Shares and Benefits** to determine *your copayment, coinsurance* and *deductible* (if any) amounts. The determination of tiers is made by *us*, through the *pharmacy and therapeutics (P&T) process*, based upon clinical information, and where appropriate, the cost of the *drug* relative to other *drugs* in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; and where appropriate certain clinical economic factors. *We* retain the right, at *our* discretion, to decide coverage for doses and administration (i.e., by mouth, shots, topical, or inhaled). Nothing in this provision shall prevent *you* from appealing *our* decision. *We* may cover one form of administration instead of another, or put other forms of administration in a different tier.

Note: *We* and/or our designated pharmacy benefits manager may receive discounts, rebates or other funds from drug manufacturers, wholesalers, distributors, and/or similar vendors, which may be related to certain drug purchases under this pharmacy program. These amounts will be retained by *us*. They will not be applied to *your deductible*, if any, or taken into account in determining your *copayments* or *coinsurance*.

Prescription Drug List

We also have a *prescription drug* list, (a *formulary*), which is a list of FDA-approved *drugs* that have been reviewed and recommended for use based on their quality and cost effectiveness.

The *drug* list is developed by *us* based upon clinical findings, and where proper, the cost of the *drug* relative to other *drugs* in its therapeutic class or used to treat the same or similar condition. It is also based on the availability of over the counter medicines, *generic drugs*, the use of one *drug* over another by *our members*, and where proper, certain clinical economic reasons.

If *you* have a question regarding whether a *drug* is on the *prescription drug formulary*, please call **Member Services** at the telephone number on the back of *your* ID card.

We retain the right, at *our* discretion, to decide coverage for doses and administration methods (i.e., oral, injected, topical, or inhaled) and may cover one form of administration instead of another as *medically necessary*. Nothing in this provision shall prevent *you* from appealing *our* decision.

Your EOC limits *prescription drug* coverage to those *drugs* listed on *our prescription drug* list. This *formulary* contains a limited number of *prescription drugs*, and may be different than the *formulary* for other *HealthKeepers'* products. Benefits may not be covered for certain *drugs* if they are not on the *prescription drug* list. Generally, it includes select *generic drugs* with limited *brand prescription drugs* coverage. This list is subject to periodic review and modification by *us*. *We* may add or delete *prescription drugs* from this *formulary* from time to time. A description of the *prescription drugs* that are listed on this *formulary* is available upon request and at www.anthem.com or by viewing www.anthem.com/VASelectdrugtier4.

Exception Request for a Drug not on the Prescription Drug List

If *you* or *your* doctor believe *you* need a *prescription drug* that is not on the *prescription drug* list, please have *your* doctor or pharmacist get in touch with *us*. *We* will act upon such requests within one (1) business day of receipt of the request. We will cover the other *prescription drug* only if *we* agree that it is *medically necessary* and appropriate over the other *drugs* that are on the list. *We* will make a coverage decision within 72 hours of receiving *your* request. If *we* approve the coverage of the *drug*, coverage of the *drug* will be provided for the duration of your prescription, including refills. If *we* deny coverage of the *drug*, *you* have the right to request an independent external review with the agency described in the "Independent External Review of Adverse Utilization Review Decisions" provision of this *EOC*. An independent external review decision will be made within 72 hours of receiving *your* request. If your independent external review, results in approval of the *drug*, coverage of the *drug* will be provided for the duration of *your* prescription, including refills.

There are two exceptions to the *formulary* requirement:

- *You* may obtain coverage without additional cost sharing beyond that which is required of *formulary prescription drugs* for a non-*formulary drug* if *we* determine, after consultation with the prescribing physician, that the *formulary drugs* are inappropriate for *your* condition.

- *You* may obtain coverage without additional cost sharing beyond that which is required of *formulary prescription drugs* for a non-*formulary drug* if:

    - *You* have been taking or using the non-*formulary prescription drug* for at least six months prior to its exclusion from the *formulary*; and
    - The prescribing physician determines that either the *formulary drugs* are inappropriate therapy for *your* condition, or that changing *drug* therapy presents a significant health risk.

You or *your* doctor may also submit a request for a *prescription drug* that is not on the *prescription drug* list based on exigent circumstances. Exigent circumstances exist if *you* are suffering from a health condition that may seriously jeopardize *your* life, health, or ability to regain maximum function, or if *you* are undergoing a current course of treatment using a *drug* not covered by the *EOC*. *We* will make a coverage decision within 24 hours of receiving *your* request. If *we* approve the coverage of the *drug*, coverage of the *drug* will be provided for the duration of the exigency. If *we* deny coverage of the *drug*, you have the right to request an independent external review with the agency described in the "Independent External Review of Adverse Utilization Review Decisions" provision of this *EOC*. An independent external review decision will be made within 24 hours of receiving *your* request. If the independent external review, results in approval of the *drug*, coverage of the *drug* will be provided for the duration of the exigency.

Coverage of a *drug* approved as a result of *your* request or *your* doctor's request for an exception will only be provided if *you* are a *member* enrolled under the *EOC*.

Covered Prescription Drugs

To be a *covered service*, *prescription drugs* must be approved by the Food and Drug Administration (FDA) and, under federal law, require a prescription. *Prescription drugs* must be prescribed by a licensed *provider* and *you* must get them from a licensed *pharmacy*.

Benefits are available for the following:

- Prescription legend *drugs* from either a retail *pharmacy* or the pharmacy benefits manager (PBM)'s home delivery pharmacy;
- *Specialty drugs;*
- *Self-administered drugs*. These are *drugs* that do not need administration or monitoring by a *provider* in an office or *facility*. Injectables and infused *drugs* that need *provider* administration and/or supervision are covered under the "*Prescription Drugs* Administered by a Medical *Provider*" benefit;
- Self-injectable insulin and supplies and equipment used to administer insulin.
- Self-administered contraceptives, including oral contraceptive *drugs*, self-injectable contraceptive *drugs*, contraceptive patches, and contraceptive rings; certain contraceptives are covered under the "Wellness Services benefit. Please see that section for more details.
- Flu shots (including administration) ; and
- Benefits will not be denied for prescription *drugs* (or inpatient or IV therapy *drugs*) used in the treatment of cancer pain, on the basis that the dosage exceeds the recommended dosage of the pain relieving agent, so long as, the *drug* is prescribed in compliance with established laws pertaining to patients with intractable cancer pain.

Retail or Home Delivery (Mail Order) Pharmacy

Your EOC includes benefits for *prescription drugs you* get at a retail or mail order *pharmacy*. *We* use a pharmacy benefits manager (PBM) to manage these benefits. The PBM has a network of retail *pharmacies*, a mail service *pharmacy*, and a specialty *pharmacy*. The PBM works to make sure *drugs* are used properly. This includes checking that prescriptions are based on recognized and appropriate doses and checking for *drug* interactions or pregnancy concerns.

You can *visit* one of the local retail pharmacies in *our* network. Give the *pharmacy* the prescription from *your* doctor and *your* identification card and they will file *your* claim for *you*. Refer to *your* **Schedule of Cost Shares and Benefits** for any *copayment, coinsurance, and/or deductible* that apply when *you* obtain *prescription drugs*. *You* may receive up to a 30-day supply of *prescription drugs* filled at the retail *pharmacy*. If *you* do not have *your* identification card, the *pharmacy* may charge *you* the full retail price of the prescription and may not be able to file the claim for *you*. *You* will need to ask the *pharmacy* for a detailed receipt and send it to *us* with a written request for payment.

If *we* determine that *you* may be using a *prescription drug* in a harmful or abusive manner, or with harmful frequency, y*our* selection of *participating pharmacies* may be limited. If this happens, *we* may require *you* to select a single *participating pharmacy* that will provide and coordinate all future pharmacy services. Benefits will be paid only if *you* use the selected single *participating pharmacy*. If *you* do not make a selection within 31 days of the date *we* notify *you*, *we* will select a single *participating pharmacy* for *you*.

Helpful tip: Benefits for *prescription drugs*, including *specialty drugs*, which must be administered to *you* in a medical setting (e.g., doctor's office, home care *visit*, or *outpatient facility*) are covered under the "Administered by a Medical Provider" benefit. Please read that section for important details.

Maintenance Medication - Home Delivery (Mail Order) Pharmacy

If *you* are taking a *maintenance medication*, *you* may get the first 30 day supply plus one additional 30 day refill of the same *maintenance medication* at *your* local retail pharmacy. In order to continue to receive benefits at the retail pharmacy level, y*ou* must contact the home delivery pharmacy before the second refill and tell them *you* would like to keep getting *your maintenance medications* from *your* local

retail *pharmacy*. If *you* do not register *your* choice, to continue getting your *maintenance medication* at the local retail pharmacy, then *you* will need to begin using the home delivery pharmacy, by following the guidelines provided below. *You* can tell *us your* choice by calling the **Member Services** telephone number on the back of *your* ID card or by visiting *our* website at www.anthem.com.

Your home delivery (mail order) prescription drug program is administered by the PBM which lets *you* get certain *drugs* by mail if *you* take them on a regular basis. *Your* mail order prescriptions are filled by an independent, licensed *pharmacy*. *HealthKeepers* does not dispense *drugs* or fill prescriptions. *You* may receive up to a 90-day supply of *maintenance medications*, with the exception of *drugs* that are in *tier four* and *specialty drugs* which are limited to a 30-day supply.

> **Helpful Tip:** If *you* decide to use home delivery choice *we* suggest that *you* order *your* refill two weeks before *you* need it to avoid running out of *your* medication. For any questions concerning the mail order program, *you* can call **Member Services** at the telephone number on the back of *your* ID card.

The *prescription* must state the dosage and *your* name and address; it must be signed by *your* physician.

The first mail order *prescription you* submit must include a completed patient profile form. This form will be sent to *you* upon becoming eligible for this program. Any subsequent mail order *prescriptions* for that insured need only the *prescription* and payment enclosed.

You must authorize the pharmacist to release information needed in connection with the filling of a *prescription* to the designated mail order *prescription drug* program.

Note: Some *prescription drugs* and/or medicines are not available or are not covered for purchase through the mail order *prescription drug* program including, but not limited to, antibiotics, *drugs* not on the *formulary*, *drugs* and medications to treat infertility, impotence and/or sexual dysfunction, injectables, including self-administered injectables, except insulin. Please check with the mail order *prescription drug* program customer service department, by calling the telephone number on the back of *your* ID card for availability of the *drug* or medication.

Specialty Pharmacy

Specialty drugs are high-cost, injectable, infused, oral or inhaled medications (including therapeutic biological products) that are used to treat chronic or complex illnesses or conditions. Specialty medications have special handling, storage and shipping requirements, such as temperature control. *Specialty drugs* may require nursing services or special programs to encourage patient compliance. *Specialty drugs* are covered only when purchased from the specialty preferred p*rovider*.

The list of *specialty drugs,* is based upon clinical findings from the *pharmacy and therapeutics (P&T) process,* and where appropriate, certain clinical economic reasons. This list will change from time to time.

Services of non-participating pharmacies

Notwithstanding any provision in this *EOC* to the contrary, *you* have coverage for *outpatient prescription drug* services provided to *you* by an out-of-network *pharmacy* that has previously notified the PBM of its agreement to accept reimbursement for its services at rates applicable to in-network pharmacies including any applicable *copayment, coinsurance* and/or *deductible* (if any) amounts as payment in full to the same extent as coverage for *outpatient prescription drug* services provided to you by an in-network *provider*. Note, however, that this paragraph shall not apply to any *pharmacy* which does not execute a *participating pharmacy* agreement with the PBM or its designee within thirty days of being requested to do so in writing by the PBM, unless and until the *pharmacy* executes and delivers the agreement.

When You Order Your Prescription through the Specialty Preferred Provider

You can only have *your prescription* for a *specialty drug* filled through *HealthKeepers'* specialty preferred p*rovider*. *Specialty drugs* are limited to a 30-day supply per fill. The specialty preferred p*rovider* will deliver *your specialty drugs* to *you* by mail or common carrier for self-administration in *your* home. *You* cannot pick up *your* medication at *HealthKeepers*.

The prescription for the *specialty drug* must state the *drug* name, dosage, directions for use, quantity, the physician's name and phone number, and the patient's name and address and be signed by a physician.

You or *your* physician may order *your specialty drug* from the specialty preferred program by calling the **Member Services** telephone number on the back of your ID card. The PBM's specialty *pharmacy* has dedicated care coordinators to help *you* take charge of *your* health problem and offers toll-free twenty-four hour access to nurses and pharmacists to answer *your* questions about *specialty drugs*. A dedicated care coordinator will work with *you* and *your* doctor to get prior authorization. When *you* call the specialty preferred p*rovider*, a dedicated care coordinator will guide *you* through the process up to and including actual delivery of *your specialty drug* to *you*. When *you* order *your specialty drug* by telephone, *you* will need to use a credit or debit card to pay for it. *You* may also submit *your specialty drug* prescription with the appropriate payment for the amount of the purchase and a properly completed order form to the specialty preferred p*rovider*. Once *you* have met *your deductible*, if any, *you* will only have to pay the cost of *your copayment* or *coinsurance* as found in the **Schedule of Cost Shares and Benefits**. When *you* order *your specialty drug* by mail, *you* will need to use a check, money order, credit or debit card to pay for it.

You or *your* physician may obtain a list of *specialty drugs* available through the specialty preferred p*rovider* network by calling **Member Services** at the telephone number on the back of *your* ID card or online at www.anthem.com. *You* or *your* physician may also obtain order forms by contacting **Member Services** or by accessing *our* web site at www.anthem.com.

Urgent or emergency need of a *specialty drug* subject to the Specialty Pharmacy Program

If *you* are out of a *specialty drug* which must be obtained through the specialty pharmacy program, *we* will authorize an override of the specialty pharmacy program requirement for 72-hours, or until the next business day following a holiday or weekend to allow *you* to get a 72-hour emergency supply of medication, or the smallest packaged quantity, whichever is greater, if *your* doctor decides that it is appropriate and *medically necessary*. *You* may have to pay the applicable *deductible/copayment/ coinsurance*, if any.

If *you* order *your specialty drug* through the specialty preferred provider and it does not arrive, if *your* physician decides that it is *medically necessary* for *you* to have the *drug* immediately, *we* will authorize an override of the specialty pharmacy program requirement for a 30-day supply or less to allow *you* to get an emergency supply of medication from a *participating pharmacy* near *you*. A customer service representative from the specialty preferred provider will coordinate the exception and *you* will not be required to pay additional *coinsurance*.

Important Details about Prescription Drug Coverage

Your EOC includes certain features to determine when *prescription drugs* should be covered, which are described below. As part of these features, *your* prescribing doctor may be asked to give more details before *we* can decide if the *drug* is *medically necessary*. *We* may also set quantity and/or age limits for specific *prescription drugs* or use recommendations made as part of *our medical policy and technology assessment* committee and/or *pharmacy and therapeutics process*.

Prescription drug benefits may depend on reviews to decide when *drugs* should be covered. These reviews may include prior authorization, step therapy, use of a *prescription drug* list, therapeutic substitution, day / supply limits, and other utilization reviews. *Your* participating pharmacist will be told of any rules when *you* fill a prescription, and will be also told about any details *we* need to decide benefits.

Drug Utilization Review

Your prescription drug benefits include utilization review of *prescription drug* usage for *your* health and safety. Certain *drugs* may require prior authorization. Also, a participating pharmacist can help arrange prior authorization or dispense an emergency amount. If there are patterns of over utilization or misuse of *drugs*, *we* will notify *your* personal physician and *your* pharmacist. *We* reserve the right to limit benefits to prevent over utilization of *drugs*.

Prior Authorization

Prior authorization may be needed for certain *prescription drugs* to make sure proper use and guidelines for *prescription drug* coverage are followed. *We* will contact *your provider* to get the details *we* need to decide if prior authorization should be given. *We* will give the results of *our* decision to both *you* and *your provider*.

If prior authorization is denied *you* have the right to file a grievance as outlined in the "Grievance and External Review Procedures" section of this *EOC*.

For a list of *drugs* that need prior authorization, please call the phone number on the back of *your* identification card or visit www.anthem.com. The list will be reviewed and updated from time to time. Including a *drug* or related item on the list does not promise coverage under *your EOC*. *Your provider* may check with *us* to verify *drug* coverage, to find out whether any quantity (amount) and/or age limits apply, and to find out which *brand name drugs* or *generic drugs* are covered under the *EOC*.

Step Therapy

Step therapy is a process in which *you* may need to use one type of *drug* before *we* will cover another. *We* check certain *prescription drugs* to make sure that proper prescribing guidelines are followed. These guidelines help *you* get high quality and cost effective *prescription drugs*. If a doctor decides that a certain *drug* is needed, the prior authorization will apply.

Administered by a Medical Provider

Your EOC also covers *prescription drugs* when they are administered to *you* as part of a doctor's *visit*, home care *visit*, or at an *outpatient* facility. This includes *drugs* for infusion therapy, chemotherapy, *specialty drugs*, blood products, and injectables that must be administered by a *provider*. This section applies when *your provider* orders the *drug* and administers it to *you*. Benefits for *drugs* that *you* inject or get at a *pharmacy* (i.e., *self-administered drugs*) are not covered under this section. Benefits for those *drugs* are described in the "Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" section.

> **Helpful tip**: When *prescription drugs* are covered under this benefit, they will not also be covered under the "Benefit at a Retail or Home Delivery (Mail Order) Pharmacy" benefit. Also, if *prescription drugs* are covered under the benefit at a retail or home delivery (mail order) pharmacy" benefit, they will not be covered under this benefit.

Additional Features

Day Supply and Refill Limits

Certain day supply limits apply to *prescription drugs* as listed in the **Schedule of Cost Shares & Benefits**. In most cases, *you* must use a certain amount of *your* prescription (e.g., 85%) before it can be refilled.

Half-Tablet Program

The half-tablet program lets *you* pay a reduced *copayment* on selected once daily dosage" *drugs* on our approved list. The program lets *you* get a 30-day supply (15 tablets) of the higher strength *drug* when the doctor tells *you* to take a "½ tablet daily." The half-tablet program is strictly voluntary and *you* should talk to *your* doctor about the choice when it is available. To get a list of the *drugs* in the program call the number on the back of *your* identification card.

Split Fill Dispensing Program

The split fill dispensing program is designed to prevent and/or minimize wasted *prescription drugs* if *your prescription drugs* or dose changes between fills, by allowing only a portion of *your* prescription to be filled at a specialty *pharmacy*. This program also saves *you* out of pocket expenses.

The *prescription drugs* that are included under this program have been identified as requiring more frequent follow up to monitor response to treatment and potential reactions or side-effects. *You* can access the list of these *prescription drugs* by calling the toll-free **Member Services** number on *your member* ID card or log on to the *member* website at www.anthem.com.

Special Programs

Except where prohibited by Federal Regulations (such as HSA rules), from time to time *we* may offer programs to support the use of more cost-effective or clinically effective *prescription drugs* including *generic drugs*, home delivery *drugs*, over the counter *drugs* or preferred products. Such programs may reduce or waive *copayments or coinsurance* for a limited time. In addition, *we* may allow access to network rates for *drugs* not listed on *our formulary*.

Claims and Member Service

For information and assistance, a *member* may call or write to *us*. The telephone number for **Member Services** is printed on the *member's* identification card.

The address of *HealthKeepers* Member Services is:

HealthKeepers, Inc.
Member Services
P.O. Box 26623
Richmond, VA 23261

Member Service Telephone

Please see the telephone number on *your member* identification card.

Prosthetic Devices and Components

Your coverage includes benefits for prosthetic devices. A prosthetic device is an artificial substitute to replace, in whole or in part, a limb or body part, such as an arm, leg, foot, or eye. Coverage is also included for the repair, fitting, adjustments, and replacement of a prosthetic device. In addition, components for artificial limbs are covered. Components are the materials and equipment needed to ensure the comfort and functioning of a prosthetic device.

Reconstructive Breast Surgery Following Mastectomy

A *member* who is getting benefits for a mastectomy or for follow-up care for a mastectomy and who chooses breast reconstruction, will also get coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to give a symmetrical appearance; and
- Prostheses and treatment of physical problems of all stages of mastectomy, including lymphedemas.

Members will have to pay the same *deductible*, *coinsurance*, and/or *copayments* that normally apply to surgeries under this *EOC*.

Reconstructive Surgery

Benefits include reconstructive surgery to correct deformities caused by congenital or developmental abnormalities, illness, injury or an earlier treatment in order to create a more normal appearance. Benefits include surgery performed to restore symmetry after a mastectomy. Reconstructive services needed as a result of an earlier treatment are covered only if the first treatment would have been a *covered service* under this *EOC*.

Note: This section does not apply to orthognathic surgery. Please see the “Surgery/Oral Surgery” provision below for benefits related to orthognathic surgery.

Rehabilitation Services

Your benefits include services in a *hospital*, free-standing *facility*, skilled nursing *facility*, or in an *outpatient* day rehabilitation program. *Covered services* include professional services and involve a coordinated team approach and several types of treatment, including skilled nursing care, physical,

occupational, and speech therapy, medical devices, and services of a social worker or psychologist. To be *covered services*, rehabilitation services must involve goals *you* can reach in a reasonable period of time. Benefits will end when treatment is no longer *medically necessary* and *you* stop progressing toward those goals.

Skilled Nursing Facility Stays

The following items and services will be provided to *you* as an *inpatient* in a skilled nursing bed of a *HealthKeepers' provider* skilled nursing *facility* or in a skilled nursing bed in a *HealthKeepers' provider hospital*:

- room and board in semi-private accommodations;
- rehabilitative services;
- general nursing services; and
- *drugs*, biologicals, and supplies furnished for use in the skilled nursing *facility* and other *medically necessary* services and supplies.

We also cover the same services shown under the ancillary services provision in this section.

Your inpatient skilled nursing *facility* benefits include a *stay* in a semi-private room unless a private room is approved in advance by *us. We* will cover the private room charge if *you* need a private room because *you* have a highly contagious condition or are at greater risk of contracting an infectious disease because of *your* medical condition. Otherwise, *your inpatient* benefits would cover the skilled nursing *facility's* charges for a semi-private room. If *you* choose to occupy a private room, *you* will be responsible for paying the daily differences between the semi-private and private room rates in addition to *your copayment* and *coinsurance* (if any).

Custodial or residential care in a skilled nursing *facility* or any other *facility* is not covered except as rendered as part of *hospice care*.

Spinal Manipulation and Manual Medical Therapy Services

Your coverage includes spinal manipulation and manual medical therapy services when performed by a *provider* within the American Specialty Health Group (ASHG). *Covered services* include examination, re-examination, manipulation, conjunctive therapy, radiology, durable *medical equipment*, and laboratory tests related to the delivery of these services.

To receive care, please visit *our* website at www.anthem.com, or contact ASHG directly for a list of ASHG *providers*. Then, simply contact a participating ASHG *provider* to make an appointment. The ASHG *provider* is responsible for obtaining authorization prior to providing care.

Out-of-plan

If *you* wish to receive care from a non-ASHG *provider*, contact ASHG directly for authorization. If authorization is not received, *you* will be responsible for all costs related to these services.

Questions concerning ASHG *providers* may be directed to ASHG's network department at 1-800-972-4226. Questions concerning coverage may be directed to ASHG's customer service department at 1-800-678-9133. Both departments are open 9:00 a.m. to midnight, Eastern Standard Time, Monday-Friday, and noon to 8:00 p.m. Eastern Standard Time, Saturday-Sunday.

Surgery

General Surgery

Your coverage includes benefits for surgery services when approved in advance by *us* and when treatment is received at an *inpatient, outpatient,* or ambulatory surgery *facility*, or doctor's office. *We* will not pay separately for pre-and post-operative services. Advance approval is not required for *emergency* services.

We cover surgical services. Surgical services are:

- operative or cutting procedures for the treatment of an illness or injury;
- *treatment* of fractures and dislocations; and/or
- endoscopic or diagnostic procedures; such as cystoscopy.

Oral Surgery

Your benefits include oral surgery for:

- surgical removal of impacted teeth;
- maxillary or mandibular frenectomy when not related to a dental procedure;
- alveolectomy when related to tooth extraction;
- orthognathic surgery that is required because of a medical condition or injury which prevents normal function of the joint or bone and is deemed *medically necessary* to attain functional capacity of the affected part;
- surgical services on hard or soft tissue in the mouth when the main purpose is not to treat or help the teeth or their supporting structures;
- treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia.

Telemedicine Services

Your coverage includes benefits for interactive *telemedicine services*, which is the use of electronic technology or media, including interactive audio or video for the purpose of diagnosing or treating a patient or consulting with other health care *providers* regarding a patient's diagnosis or treatment. *Telemedicine services* do not include an audio-only telephone conversations, electronic mail message, facsimile transmission or online questionnaire.

Therapy

Your EOC covers the following therapies when the treatment is *medically necessary* for *your*

condition, and provided by a licensed therapist or any other *provider* that meets the definition of *provider* under this *EOC*:

Cardiac rehabilitation therapy

Your coverage includes benefits for cardiac rehabilitation which is the process of relearning, regaining, restoring, improving, and maintaining the physiological, psychological, social and vocational capabilities of patients with heart disease.

Chemotherapy

Your coverage includes benefits for the treatment of disease by chemical or biological antineoplastic agents.

Habilitative Services

Your coverage includes benefits for *habilitative services* that help *you* keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of *inpatient* and/or *outpatient* settings.

Physical, occupational and speech therapy

Your coverage includes benefits for short-term physical, occupational, and speech therapy when the treatment is *medically necessary* for *your* condition. In the judgment of *HealthKeepers,* short-term rehabilitative therapy services can be expected to result in significant improvement of *your* condition within 90 consecutive days of beginning *outpatient* treatment. Refer to *your* **Schedule of Cost Shares and Benefits** for limitations, *copayment* and *coinsurance* amounts.

Physical therapy is treatment by physical means to relieve pain, restore function, and prevent disability following disease, injury, or loss of limb. *Your* coverage includes benefits for physical therapy to treat lymphedema.

Occupational therapy is treatment to restore a physically disabled person's ability to perform activities such as walking, eating, drinking, dressing, toileting, transferring from wheelchair to bed and bathing.

Speech therapy is treatment for the correction of a speech impairment which results from disease, surgery, injury, congenital anatomical anomaly or prior medical treatment.

Helpful tip: Long term therapy or rehabilitative care is excluded unless otherwise specified in this *EOC* as covered under the Early Intervention Services provision.

Radiation therapy

Your benefits include the treatment of an illness by x-ray, radium, cobalt, or radioactive isotopes. *Covered services* include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), rental or purchase costs of radioactive materials and supplies needed, administration, and treatment planning.

Respiratory therapy

Your benefits include respiratory therapy, which is the introduction of dry or moist gases into the lungs to treat illness or injury.

Transplant: Human Organ and Tissue Transplant (Bone Marrow/Stem Cell)

This section describes benefits for certain *covered transplant procedures* that *you* get during the *transplant benefit period*. Any *covered services* related to a covered transplant procedure, received before or after the *transplant benefit period*, are covered under the regular *inpatient* and *outpatient* benefits described elsewhere in this *EOC*.

Covered Transplant Procedure

Any *medically necessary* human organ and stem cell / bone marrow transplants and infusions as determined by *us*, including necessary acquisition procedures, mobilization, collection, and storage, and including *medically necessary* myeloablative or reduced intensity preparative chemotherapy or radiation therapy or a combination of these therapies.

In-Network Transplant Provider

A *provider* that *HealthKeepers* has chosen as a Center of Medical Excellence and/or a *provider* selected to take part as an *in-network transplant provider* by the Blue Cross and Blue Shield Association.

The *provider* has entered into a transplant provider agreement to give *covered transplant procedures* to *you* and take care of certain administrative duties for the transplant network. A *provider* may be an *in-network transplant provider* for:

- Certain *covered transplant procedures*; or
- All *covered transplant procedures*

Out-of-Network Transplant Provider

Any *provider* that has **NOT** been chosen as a Center of Medical Excellence and/or a *provider* selected to take part as an *in-network transplant* provider by the Blue Cross and Blue Shield Association.

Unrelated Donor Searches

When approved by *us your* coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a *covered transplant procedure*.

Live Donor Health Services

Medically necessary charges for the procurement of an organ from a live donor are covered up to the *maximum allowed amount*, including complications from the donor procedure for up to six weeks from the date of procurement.

Transplant Benefit Period

Starts one day prior to a *covered transplant procedure* and continues for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the *in-network transplant provider* agreement. Contact the case manager for specific *in-network transplant provider* information for services received at or coordinated by an *in-network transplant provider facility*. Services received from an out-of-network transplant *facility* starts one day prior to a *covered transplant procedure* and continues to the date of discharge.

Prior Approval and Precertification

In order to maximize *your* benefits, *you* will need to call *our* transplant department to discuss benefit coverage when it is determined a transplant may be needed. ***You* must do this before *you* have an evaluation and/or work-up for a transplant.** *Your* evaluation and work-up services must be provided by an *in-network transplant provider* to receive maximum benefits. *We* will assist *you* in maximizing *your* benefits by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, *in-network transplant provider* requirements, or exclusions are applicable. Even if a *hospital* is an in-network *provider* for other services, it may not be an *in-network transplant provider* for certain transplant services. Please call us to find out which *hospitals* are *in-network transplant providers*. Contact the **Member Services** telephone number on the back of *your* identification card and ask for the transplant coordinator. Even if *we* issue a prior approval for the *covered transplant procedure*, *you* or *your provider* must call *our* transplant department for precertification prior to the transplant whether this is performed in an *inpatient* or *outpatient* setting.

Helpful tip: Receiving transplant evaluation and **work- up** services at an in-network transplant *facility* will maximize *your* benefits.

Please note that there are instances where *your provider* requests approval for Human Leukocyte Antigen (HLA) testing, donor searches and/or a collection and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing. The collection and storage request will be reviewed for *medical necessity* and may be approved. However, such an approval for HLA testing, donor search services performed by an authorized registry and/or a collection and storage is NOT an approval for the subsequent requested transplant. A separate *medical necessity* determination will be made for the transplant procedure.

Transportation and Lodging

We will provide assistance with reasonable and necessary travel expenses as determined by *us* when *you* obtain prior approval and are required to travel more than 75 miles from *your* residence to reach the *facility* where *your* transplant evaluation and /or transplant work-up and *covered transplant procedure* will be performed. *Our* assistance with travel expenses includes transportation to and from the *facility* and lodging for the patient and one companion. If the *subscriber* receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. The *subscriber* must submit itemized receipts for transportation and lodging expenses in a form satisfactory to *us* when claims are filed. Contact *us* for detailed information.

For lodging and ground transportation benefits, *we* will provide a maximum benefit up to the current limits set forth in the Internal Revenue Code.

Non-*covered services* for transportation and lodging include, but are not limited to:

- Meals,
- Child care,
- Mileage within the medical transplant *facility* city,
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by *us*,
- Frequent Flyer miles,
- Coupons, Vouchers, or Travel tickets,
- Prepayments or deposits,
- Services for a condition that is not directly related, or a direct result, of the transplant,
- Telephone calls,
- Laundry,
- Postage,
- Entertainment,
- Travel expenses for donor companion/caregiver,
- Return *visits* for the donor for a treatment of a condition found during the evaluation.

The human organ and tissue transplant (bone marrow/stem cell) services benefits or requirements described above do not apply to the following:

- Cornea, ventricular assist devices; and

- Any *covered services*, related to a *covered transplant procedure*, received prior to or after the *transplant benefit period*. Please note that the initial evaluation and any necessary additional testing to determine *your* eligibility as a candidate for transplant by *your provider* and the mobilization, collection and storage of bone marrow / stem cells is included in the *covered transplant procedure* benefit regardless of the date of service.

The above services are covered as *inpatient* services, *outpatient* services or physician home *visits* and office services depending where the service is performed subject to *subscriber cost shares*.

Helpful tip: See the **Schedule of Cost Shares and Benefits** for any applicable *deductible*, *coinsurance*, *copayment*, and benefit limitation information.

Pediatric Vision Care

The following vision care benefits are available to *members* up to the end of the month in which they turn age 19. *We* will cover vision care that is listed in this section. See *your* **Schedule of Cost Shares & Benefits** for the benefit frequencies and *your cost share* amounts for covered vision care. To get the in-network benefits, *you* must use a Blue View Vision provider. If *you* need help finding a Blue View Vision

provider, please visit *our* website or call the number on your ID card. *We* will not pay for vision care listed in the "**What Is Not Covered**" (Vision Care) section.

Routine Eye Exam

Your EOC covers a complete eye exam with dilation as needed. The exam is used to check all aspects of *your* vision.

Eyeglass Lenses

You have a choice in *your* eyeglass lenses. Lenses include factory scratch coating and UV coating, standard polycarbonate and standard photochromic lenses at no additional cost when received from in-network *providers*. If *you* choose lens options that are not listed as covered in the **Schedule of Cost Shares & Benefits**, *you* will have to pay all charges for those options.

Covered eyeglass lenses include standard plastic (CR39) lenses up to 55 mm in:

- single vision
- bifocal
- trifocal (FT 25-28)
- progressive

Frames

A selection of frames is covered under *your EOC*. *Members* must choose a frame from the Anthem *formulary*.

Elective Contact Lenses*

Elective contact lenses are contacts that *you* choose instead of eyeglasses for comfort or appearance. *You* may choose elective contact lenses in lieu of *your* eyeglass lenses benefit.

Non-Elective Contact Lenses*

Non-elective contacts are only provided for the following medical conditions:

- Keratoconus where the patient is not correctable to 20/40 in either or both eyes using standard spectacle lenses.
- High Ametropia exceeding -12D or +9D in spherical equivalent.
- Anisometropia of 3D or more.
- Patients whose vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

*If *you* receive elective or non-elective contact lenses then no benefits will be available for eyeglass lenses until *you* satisfy the benefit frequency listed in the **Schedule of Cost Shares and Benefits**. A selection of contact lenses is covered under this *EOC*. *Members* must choose contact lenses from the Anthem formulary.

SPECIAL NOTE: *We* will not reimburse for Non-Elective Contact Lenses for any *member* who has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

This *EOC* only covers a choice of contact lenses or eyeglass lenses, but not both. If *you* choose contact lenses during a benefit period, no benefits will be available for eyeglass lenses until the next benefit period. If you choose eyeglass lenses during a benefit period, no benefits will be available for contact lenses until the next benefit period.

Vision Correction after Surgery or Accident

In situations such as those defined below, y*our* coverage includes the cost of prescribed eyeglasses or contact lenses only when required as a result of surgery, or for the treatment of accidental injury. Services for materials, fittings, exams and replacement of these eyeglasses or contact lenses will be covered only

if the prescription change is related to the condition that required the original prescription. The purchase and fitting of eyeglasses or contact lenses are covered if:

- prescribed to replace the human lens lost due to surgery or injury;
- "pinhole" glasses are prescribed for use after surgery for a detached retina; or
- lenses are prescribed instead of surgery in the following situations:
  - contact lenses are used for the treatment of infantile glaucoma;
  - corneal or scleral lenses are prescribed in connection with keratoconus;
  - scleral lenses are prescribed to retain moisture when normal tearing is not possible or not adequate; or
  - corneal or scleral lenses are required to reduce a corneal irregularity other than astigmatism.

Wellness Services

Your coverage provides for preventive care services for children, adolescents and adults. Preventive care services generally include check-up *visits*, developmental assessment and guidance, screening tests, intervention counseling/education services, immunizations and other services to prevent the development of disease, or allow the detection of medical conditions in advance. Nutritional counseling is covered when received as part of a covered wellness service screening.

Services are covered as preventive care for children, adolescents and adults with no current symptoms or prior history of the medical condition associated with the screening or service. *Members* who have current symptoms or have been diagnosed with a medical condition are not considered to require preventive care for that condition, but instead benefits will be considered under the diagnostic services benefit.

Additionally, a routine preventive screening may identify abnormalities or problems that require immediate intervention or additional diagnosis. If this occurs, and *your provider* performs additional necessary *covered services,* these services will generally be covered as diagnostic and/or surgical services and not as preventive care services. Also, covered screenings that *you* undergo because *you* have a personal or family history of a particular condition are not generally covered as preventive care services. *Deductibles, copayments,* and *coinsurance* amounts applicable to diagnostic and/or surgical services may be different from those applicable to preventive care services. Please see the **Diagnostic Tests** and **Surgery** sections on the **Schedule of Cost Shares and Benefits** for more information.

The preventive care services in this section meet the requirements outlined under federal and *state* law. Many preventive care services covered by *your EOC* are not subject to *cost shares* (for example, *deductible, copayment,* and/or *coinsurance* amounts). That means *HealthKeepers* pays 100% of the *maximum allowed amount*. These services fall under four broad categories as shown below:

1. Services with an “A” or “B” rating from the United States Preventive Services Task Force. Examples of these services are screenings for:
   - Breast cancer;
   - Cervical cancer;
   - Colorectal cancer;
   - High blood pressure;
   - Type 2 diabetes mellitus;
   - Cholesterol;
   - Child and adult obesity.
2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

3. Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration including infant hearing screening; and

4. Preventive care and screening for women as listed in the guidelines supported by the Health Resources and Services Administration, including:

    a. Women's contraceptives including all Food and Drug Administration (FDA)-approved contraceptive methods, sterilization procedures, patient education and counseling.

    b. Contraceptive coverage includes *generic drugs* and *single-source brand name drugs* as well as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. *Multi-source brand name* drugs will be covered, as preventive care benefits when *medically necessary*, otherwise they will be covered under the "Prescription Drug Benefit at a Retail or Home Delivery (Mail Order) Pharmacy."

    c. Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one per calendar year or as required by law.

    d. Gestational diabetes screening for women 24 to 28 weeks pregnant, and those at high risk of developing gestational diabetes.

    e. Testing for Human Papillomavirus (HPV) every three years for women who are 30 or older and at high risk, regardless of Pap smear results.

    f. Annual screening and counseling for sexually transmitted infections (STIs) and Human Immunodeficiency Virus (HIV) for sexually active women.

    g. Routine mammogram screenings.

    h. Screening and counseling for interpersonal and domestic violence.

    i. Well woman *visits*, including *visits* for contraceptive management.

    j. BRCA risk assessment screening and genetic counseling /testing.

You may call **Member Service** at the telephone number on *your* identification card for additional information about these services. *You* may also *visit* the federal government websites:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits
- http://www.ahrq.gov
- http://www.cdc.gov/vaccines/acip/index.html

5. Counseling services related to smoking and tobacco use cessation.

6. *Your* coverage also includes prostate cancer screenings including digital rectal exam and PSA test, as required by *state* law.

What is Not Covered (Exclusions)

This list of services and supplies are excluded from coverage under this *EOC.* They will not be covered in any case.

A

Your coverage does not include benefits for **abortions** for which Federal funding is not allowed in accordance with Affordable Care Act section 1303(b)(1)(B)(i), namely all abortions except in the case of rape or incest, or for a pregnancy which, as certified by a *physician*, places the woman in danger of death unless an abortion is performed.

Your coverage does not include benefits for **ambulance** when another type of transportation can be used without endangering the *member's* health. Any ambulance usage for the convenience of the *member*, family or physician is not a *covered service*. Non *covered services* for ambulance include but are not limited to, trips to:

- A physician's office or clinic;
- A morgue or funeral home.

Coverage is not available for air ambulance transport from a *hospital* capable of treating the patient because the patient and/or the patient's family prefer a specific *hospital* or physician. Air ambulance services are not covered for transport to a *Hospital* that is not an acute care *hospital*, such as a nursing *facility,* physician's office, or *your* home.

Your coverage does not include benefits from **affiliated providers** such as a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, academic institution, or similar person or group.

Your coverage does not include additional charges beyond the *maximum allowed amount* for basic and primary services for services requested **after normal *provider* service hours** or on holidays.

Your coverage does not include the following **allergy tests and treatment**:
a. IgE RAST tests unless intradermal tests are contraindicated.
b. Allergy tests for non-specific or non-allergy related symptoms such as fatigue and weight gain.
c. Food allergy test panels (including SAGE food allergy panels).
d. Services for, and related to, many forms of immunotherapy. This includes, but is not limited to, oral immunotherapy, low dose sublingual immunotherapy, and immunotherapy for food allergies.

Your coverage does not include benefits for injuries or sicknesses sustained while serving in any branch of the **Armed Services**. Once *you* tell *us you* have entered into the Armed Services, *we* will refund *your* pro-rated *premium*. However, if *you* are in a National Guard unit that has been activated, *you* have the choice of continuing or terminating this *EOC*.

Your coverage does not include benefits related to **artificial and/or mechanical hearts or ventricular** and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This exclusion includes services for implantation, removal and complications. This exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.

Your coverage does not include benefits for services received which are not **authorized in advance by *HealthKeepers,* and pre-arranged by *your PCP,*** unless otherwise specified in this *EOC.*

B

Your coverage does not include benefits for **bariatric surgery**, regardless of the purpose it is proposed or performed. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. *Your* coverage does not include benefits for services and supplies related to obesity or services 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.

Your coverage does not include benefits for **biofeedback therapy.**

Your coverage does not include benefits for the removal or replacement of a **breast implant** that was initially done for augmentation or for cosmetic purposes . Reduction or augmentation mammoplasty is excluded unless associated with breast reconstruction surgery following a *medically necessary* mastectomy resulting from cancer.

C

Complications directly related to a service or treatment that is a non *covered service* under this *evidence of coverage* because it was determined by *us* to be *experimental/investigative* or non *medically necessary*. Directly related means that the service or treatment occurred as a direct result of the *experimental/investigative* or non *medically necessary* service and would not have taken place in the absence of the *experimental/investigative* or non *medically necessary* service.

Your coverage does not include benefits for personal hygiene, environmental control, or **convenience** items including but not limited to:

- Air conditioners, humidifiers, air purifiers;
- Health club membership, and physical fitness equipment such as a treadmill or exercise cycles; 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 or similar facilities.
- Special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program;
- Personal comfort and convenience items during an *inpatient stay*, including but not limited to daily television rental, telephone services, cots or visitor's meals;
- Charges for non-medical self-care except as otherwise stated;
- Purchase or rental of supplies for common household use, such as water purifiers; Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds; Safety helmets for *members* with neuromuscular diseases; or Sports helmets.

Your coverage does not include benefits provided in connection with **cosmetic services**. Cosmetic services are primarily intended to preserve, change or improve *your* appearance or are furnished for psychiatric, psychological or social reasons. No benefits are available for surgery or treatments to change the texture or appearance of *your* skin or to change the size, shape or appearance of facial or body features (such as *your* nose, eyes, ears, cheeks, chin, chest or breasts). Complications directly related to cosmetic services, treatment or surgery, as determined by *us*, are not covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the *member* was covered by another carrier/self-funded plan prior to coverage under this *EOC*. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including but not limited to: myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions. This exclusion also does not apply to plastic or reconstructive surgery to restore breast symmetry by reduction mammoplasty, mastopexy or breast augmentation as recommended by the oncologist or *PCP* for a *member* incident to a covered mastectomy. Coverage will include reduction or uplift surgery on the unaffected breast to produce a symmetrical appearance. *HealthKeepers* will not consider the patient's mental state in deciding if the surgery is cosmetic.

Your coverage does not include benefits for **counseling services** and treatment related to religious counseling, vocational or employment counseling, and sex therapy.

Your coverage does not include benefits for **court ordered** testing or care, unless the service is *medically necessary* and authorized by *us*.

Your coverage does not include services, supplies, etc. for the following:

a) **Custodial care**, convalescent care or rest cures.
b) Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a *member's* own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
c) Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care *facility* home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar *facility* or institution.
d) Services or care provided or billed by a school, custodial care center for the developmentally disabled, or outward programs, even if psychotherapy is included.
e) Wilderness camps.

The fact that the care or services described above have been recommended, provided, performed, prescribed, or approved by a physician or other *provider* will not establish that the care or services are *covered services*.

D

Coverage is NOT provided for the following **Dental** related services:

- Dental care for *members* age 19 and older.
- Dental services not listed as covered in this *EOC*.
- Services of anesthesiologists, unless required by law.

- Intravenous and non-intravenous conscious sedation, analgesia, and general anesthesia when given separate from a covered oral surgery service and given by a dentist or by an employee of the dentist when the service is performed in his or her office who is certified in their profession to provide anesthesia services.
- Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
- Canal prep & fitting of preformed dowel & post.
- Occlusal procedures.
- Onlays or permanent crowns when the tooth does not have decay, fracture or has been endodontically treated.
- Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding.
- Case presentations.
- Athletic mouth guards, enamel microabrasion and odontoplasty.
- Retreatment or additional treatment necessary to correct or relieve the results of treatment previously benefited under *your EOC*.
- Bacteriologic tests for determination of periodontal disease or pathologic agents.
- The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
- Collection of oral cytology sample via scraping of the oral mucosa.
- Separate services billed when they are an inherent component of another *covered service*.
- Pin retention is not covered when billed separately from restoration procedure.
- Services for the replacement of an existing partial denture with a bridge.
- Incomplete, interim or temporary services, including but not limited to fixed prosthetic appliances (dentures, partials or bridges).
- Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
- Placement or removal of sedative filling, base or liner used under a restoration when it is billed separately from a restoration procedure.
- Pulp vitality tests.
- Adjunctive diagnostic tests.
- Analgesia, analgesia agents, anxiolysis nitrous oxide, medicines, or drugs for non-surgical or surgical dental care.
- Incomplete root canals.
- Cone beam images.
- Anatomical crown exposure.
- Temporary anchorage devices.
- Sinus augmentation.
- Oral hygiene instructions.

- Repair or replacement of lost/broken appliances.
- Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
- Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.

Your coverage does not include benefits for **dental x rays, supplies & appliances** and all associated expenses, including hospitalization and anesthesia; except as required by law or specifically stated as a *covered service*. The only exceptions to this are for any of the following:

- Transplant preparation.
- Initiation of immunosuppresives.
- Treatment of traumatic injury, cancer, or cleft palate.

Your coverage does not include benefits for **donor** searches for organ or tissue transplants, including compatibility testing of potential donors who are not immediate blood-related family *members* (parent, child, sibling), except as required by law or specifically stated as a *covered service*.

E

Your coverage does not include benefits for services or supplies primarily for **educational,** vocational, or self management/training purposes**,** except as otherwise specified in this *EOC* or when received as a part of covered wellness services.

Your coverage does not include benefits for **examinations** relating to research screenings.

Your coverage does not include benefits which are ***experimental/investigative*** or related to such, whether incurred prior to, in connection with, or subsequent to the *experimental/investigative* service or supply, as determined by *us*, with the exception of *clinical trials* required to be covered by law. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if *we* deem it to be *experimental/investigative*.

F

Your coverage does not include benefits for the following **family planning** services:

- services for assisted reproductive technologies (ART) or the diagnostic or surgical procedures and *drugs* to support it. This includes artificial insemination, in-vitro fertilization, zygote intrafallopian transfer (ZIFT), or gamete intrafallopian transfer (GIFT);
- any services or supplies provided to a person not covered under this *EOC* in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple);
- *prescription drugs* used to treat infertility;
- reversal of sterilization; or

- non-prescription contraceptive devices.

Your coverage does not include benefits for services for palliative or cosmetic **foot** care are including:

- routine foot care (including the cutting or removal of corns and calluses): nail trimming, cutting or debriding; hygienic and preventive maintenance foot care (except as treatment for patients with diabetes or vascular disease); including but not limited to, cleaning and soaking the feet, applying skin creams in order to maintain skin tone. and other services that are performed when there is not a localized illness, injury or symptom involving the foot.
- 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 (except as treatment for patients with diabetes or vascular disease);
- bunions (except capsular or bone surgery);
- calluses (except as treatment for patients with diabetes or vascular disease);
- care of toenails (except as treatment for patients with diabetes or vascular disease);
- fallen arches;
- weak feet;
- chronic foot strain;
- symptomatic complaints of the feet; or surgical treatment of flat feet; strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.

G

Your coverage does not include services for surgical treatments of **gynecomastia**.

Your coverage does not include services for which payment is available to *you* under any Federal or *state* **government program** (except Medicaid), or under any program to which the government contributes money. These programs include, but are not limited to:

- Veterans Administration (VA) Hospitals; and
- Occupational Disease Law.

This exclusion applies whether or not *you* waive *your* rights to payment. However, *we* will provide benefits once *your* benefits are exhausted under government-financed programs.

This exclusion does not apply to services available to *you* through the Virginia Department of Medical Assistance Services (Medicaid). The Department is the payor of last resort to any health care insurance carrier which contracts to pay health care costs for persons eligible for medical assistance in the Commonwealth of Virginia provided under federal, *state*, or local laws and regulations. This includes 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 *EOC* have been paid. *HealthKeepers* 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; *Your* coverage does not include benefits for services or supplies if they are provided or available to a *member*.

- under the Medicare program or under any similar program authorized by *state* or local laws or regulations or any future amendments to them. This exclusion does not apply to those laws or regulations which make the government program the secondary payor after benefits under this *EOC* have been paid.

- To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.

This exclusion applies whether or not the *member* waives his or her rights under these laws, amendments, programs or terms of employment. However, *HealthKeepers* will provide the *covered services* specified in this *EOC* when benefits under these programs have been exhausted.

H

Your coverage does not include benefits for **hearing aids** or for examinations for prescribing or fitting them, except as specified in the "What is Covered" section of this *evidence of coverage*.

Your coverage does not include benefits for the following ***home care services:***

- services not listed in *your* physician's approved plan of treatment;
- vocational guidance, and similar or related services;
- recreational or social activities;
- homemaker services (except as rendered as part of *hospice care*);
- maintenance therapy;
- food and home delivered meals; and
- custodial care and services.

Your coverage does not include benefits for the following ***hospice care* services**:

- services or supplies for personal comfort or convenience;
- food services, meals, formulas and supplements other than listed above or for dietary counseling even if the food, meal, formula or supplement is the sole source of nutrition, except as covered under the diabetic supplies, equipment, and education and wellness services provisions in the What is covered section of this *EOC*;
- services not directly related to the medical care of the *member*, including estate planning, drafting of wills, funeral counseling or arrangement or other legal services; and, services provided by volunteers.

Your coverage does not include benefits for the following ***hospital*** services:

- private duty nursing;
- 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;* or

- a private room unless it is *medically necessary* and approved by *us.*

Your coverage does not include benefits for **human growth hormone**.

Your coverage does not include benefits for treatment of **hyperhydrosis** (excessive sweating).

I

Your coverage does not include benefits for physical exams and **immunizations** required for travel, work or for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes, unless such services are received as part of the covered preventive care services as defined in this *EOC*.

Your coverage does not include benefits for care required while **incarcerated** in a federal, *state* or local penal institution or required while in custody of federal, *state* or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.

M

Your coverage does not include benefits for **maintenance therapy**, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves *your* present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.

Your coverage does not include benefits for **manipulation therapy** services rendered in the home unless specifically stated as covered under the *home care services* benefit.

Your coverage does not include benefits for ***medical equipment (durable),*** **appliances, devices, and supplies** that have both a non-therapeutic and therapeutic use. These include but are not limited to:

- exercise equipment;
- air conditioners, dehumidifiers, humidifiers, and purifiers;
- hypoallergenic bed linens, bed boards;
- 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; or
- repair or replacement of equipment *you* lose or damage through neglect.

Your coverage does not include benefits for ***medical equipment (durable)*** that is not appropriate for use in the home.

Your coverage does not include benefits for services or supplies if they are deemed not ***medically necessary*** as determined by *us* at *our* sole discretion. Nothing in this exclusion shall prevent *you* from appealing *our* decision that a service is not *medically necessary*.
However, if *you* receive *inpatient* or *outpatient* services that are denied as not *medically necessary,* or are denied for failure to obtain the required pre-authorization, the following professional *provider* services that *you* receive during *your inpatient stay* 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:

For *inpatients*
1. services that are rendered by professional *providers* who do not control whether *you* are treated on an *inpatient* basis, such as pathologists, radiologists, anesthesiologists, and consulting physicians.

2. services rendered by *your* attending *provider* other than *inpatient* evaluation and management services provided to *you. Inpatient* evaluation and management services include routine *visits* by *your* attending *provider* for purposes such as reviewing patient status, test results, and patient medical records. *Inpatient* evaluation and management *visits* do not include surgical, diagnostic, or therapeutic services performed by *your* attending *provider*.

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

Your coverage does not include benefits for **medical devices** and appliances such as to cover corrective shoes, shoe inserts (including molded shoe inserts), heel cups, heel pads, foot orthotics or arch supports. *We* do not cover prosthetic devices, orthopedic appliances and orthopedic braces if they are used solely for sports or recreational activities.

Your coverage does not include (1) benefits which are payable under **Medicare** Parts A, B and/or D, or would have been payable if a *member* had applied for Parts A, B, and/or D, except, as specified elsewhere in this *EOC* or as otherwise prohibited by federal law, as addressed in the provision titled "Medicare" in the "If You are Covered by More than One Policy" section. For the purposes of the calculation of benefits, if the *member* has not enrolled in Medicare Part B, *we* will calculate benefits as if the *member* had enrolled; (2) services or supplies provided pursuant to a private contract between the *member* and a *provider*, for which reimbursement under the Medicare program is prohibited as specified in Section 1802 (42 U.S.C. 1395a) of Title XVII of the Social Security Act.

Your coverage does not include benefits for the following ***mental health and substance use disorder services*:**

- educational therapy;
- vocational and recreational activities;
- coma stimulation therapy; or
- remedial or special education services.

This *EOC* excludes all *treatment* for the following behavioral/social conditions:

- social maladjustment without apparent mental health disorder;
- group delinquent reaction of childhood;

- conduct disorders; and
- oppositional disorders.

This *EOC* excludes the following forms of *treatment*:

- services directed toward making one's personality more forceful or dynamic;
- consciousness raising;
- vocational or religious counseling;
- group socialization;
- activities primarily of an educational nature;
- educational therapy;
- vocational and recreational therapy. Recreational therapy includes; but is not limited to, dance, art, crafts, aquatic, hydro, gambling and nature therapy;
- coma stimulation therapy;
- self-help training, and self-administered services, including biofeedback and related testing;
- behavioral modification; and
- modalities which include: primal therapy; rolfing or structural integration, bioenergetic therapy; carbon dioxide therapy; guided imagery; Z-therapy; obesity control therapy; training analysis; sedac therapy; dance therapy; music therapy and art therapy.

IMPORTANT: If a covered person has a behavioral/social problem that is manifested from a mental illness, the treatment for the mental illness is covered, not the treatment for the behavioral/social problem.

N

Your coverage does not include benefits for which *you* have **no legal obligation to pay** in the absence of this or like coverage.

Your coverage does not include benefits for care received in an emergency room that is **not *emergency* care**, except for the initial screening and *stabilization* of the patient, or as otherwise specified in this *EOC*. This includes, but is not limited to, suture removal in an emergency room.

Your coverage does not include benefits for **nutritional and dietary supplements**, except as provided in the "What is Covered" section of this *EOC* 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 the written prescription or dispensing by a licensed pharmacist.

O

Your coverage does not include benefits for drugs, devices, products, or supplies with **over the counter** equivalents and any drugs, devices, products, or supplies that are therapeutically comparable to an over the counter drug device, product, or supply, unless specifically stated as a *covered service* in this *EOC* or as required by law.

Your coverage does not include benefits for services rendered by *providers* located **outside the United States**, unless the services are for *emergency* care, urgent care and *emergency* ambulance .

P

Your coverage does not include benefits for **paternity testing.**

Your coverage does not include benefits for the following physician or other practitioners' charges:

a. **Physician or other practitioners' charges** for consulting with *members* by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the *member.*
b. Surcharges for furnishing and/or receiving medical records and reports.
c. Charges for doing research with *providers* not directly responsible for *your* care.
d. Charges that are not documented in *provider* records.
e. Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending physician.
f. Charges for membership, administrative, or access fees charged by physicians or other *providers*. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.

Your ***prescription drug*** benefit does not cover:

- Administration charges - charges for the administration of any *drug* except for covered immunizations as approved by *us* or the pharmacy benefits manager (PBM).
- Clinically-equivalent alternatives - certain *prescription drugs* are no longer covered when clinically equivalent alternatives are available unless otherwise required by law, or is otherwise determined by *us* to be *medically necessary*. In order for that *prescription drug* to be considered *medically necessary*, the physician must substantiate to *us*, in writing, a statement that includes the reasons why use of that *prescription drug* is more medically beneficial than the clinically equivalent alternative.
- Compound drugs
- Contrary to approved medical and professional standards - *drugs* given to *you* or prescribed in a way that is against approved medical and professional standards of practice.
- Delivery charges - charges for delivery of *prescription drugs*.
- *Drugs* given at the *provider's* office / *facility* - *drugs you* take at the time and place where *you* are given them or where the prescription order is issued. This includes samples given by a doctor. This exclusion does not apply to *drugs* used with a diagnostic service, *drugs* given during chemotherapy in the office as described in the "Therapy Services" section, or *drugs* covered under the "Medical Supplies" benefit – they are *covered services*.

- Drugs that do not need a prescription - drugs that do not need a prescription by federal law (including drugs that need a prescription by *state* law, but not by federal law), except for injectable insulin. This exclusion does not apply to over-the-counter drugs that *we* must cover under federal law when recommended by the U.S. Preventive Services Task Force and prescribed by a physician.
- *Drugs* over quantity or age limits - *drugs* in quantities which are over the limits set by *us*, or which are over any age limits set by *us*.
- *Drugs* over the quantity prescribed or refills after one year - *drugs* in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original prescription order.
- Items covered as *durable medical equipment (DME)* - therapeutic DME, devices and supplies except peak flow meters, spacers, blood glucose monitors.
- Over the counter drugs, devices or products are not *covered services*.
- An allergenic extract or vaccine.
- Lost or stolen *drugs* - refills of lost or stolen *drugs*.
- Mail service programs other than the PBM's home delivery mail service - p*rescription drugs* dispensed by any mail service program other than the PBM's home delivery mail service, unless *we* must cover them by law.
- Non-approved drugs - drugs not approved by the FDA.
- Off label use - Off label use, unless *we* must cover the use by law or if *we*, or the PBM, approve it.
- Onychomycosis *drugs* - *drugs* for onychomycosis (toenail fungus) except when *we* allow it to treat *members* who are immuno-compromised or diabetic.
- Sex change *drugs* - *drugs* for sex change surgery.
- Sexual dysfunction *drugs* - *drugs* to treat sexual or erectile problems.
- Syringes hypodermic syringes except when given for use with insulin and other covered self-injectable *drugs* and medicine.
- Weight loss *drugs* - any *drug* mainly used for weight loss.
- *Drugs* used for cosmetic purposes.
- *Prescription drugs* used to treat infertility.

Your coverage does not include benefits for **private duty nursing** services in an *inpatient* setting.

***Provider* services** *you* get from *providers* that are not licensed by law to provide *covered services*, as defined in this *EOC*. Examples of such *providers* may include, but are not limited to, masseurs or masseuses (massage therapists) and physical therapist technicians.

R

Your coverage does not include benefits for **reconstructive services** except as specifically stated in the What is Covered section, or as required by law.

Your coverage does not include benefits for services which are solely performed to prevent **regression of functions** for an illness, injury or condition which is resolved or stable.

Your coverage does not include benefits for 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 services.

Your coverage does not include benefits for care from a **residential treatment center** or other non-skilled settings, except to the extent as required by law or specifically stated as a *covered service*, and such setting qualifies as a substance use disorder 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.

Your coverage does not include benefits for a condition resulting from direct participation in a **riot,** civil disobedience, being intoxicated, influence of an illegal substance, nuclear explosion, nuclear accident or engaging in an illegal occupation.

S

Your coverage does not include benefits for treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including **sclerotherapy** or other surgeries) for cosmetic purposes.

Your coverage does not include benefits for **self-help training** and other forms of non-medical self care, except as otherwise provided herein.

Your coverage does not include benefits for **services, supplies, or devices** if they are:

- received from an individual or entity that is not a *provider*, as defined in this *EOC*, or recognized by *us;*
- separate charges for services by health care professionals employed by a *facility* which makes their services available;
- not listed as covered under this *EOC;*
- not prescribed, performed, or directed by a *provider* licensed to do so;
- charges incurred after the termination date of this coverage;
- incurred prior to *your effective date*;
- telephone consultations, charges for not keeping appointments, or charges for completing claim forms;
- prescribed, ordered or referred by, or received from a *member* of *your* immediate family, including *your* spouse, child/stepchild, brother/stepbrother, sister/stepsister, parent/stepparent, in-law, or self; or
- for stand-by charges of a physician.

Your coverage does not include benefits for **services** for which a charge is not usually made. This includes services for which *you* would not have been charged if *you* did not have health care coverage.

Your coverage does not include benefits for:

- amounts above the *maximum allowed amount* for a service;
- neurofeedback and related diagnostic tests;
- acupuncture;
- the following 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 from birth to age three who qualify for Early Intervention services;
- group speech therapy; or
- group or individual exercise classes or personal training sessions.

Your coverage does not include benefits for services and supplies related to **sex transformation** and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, *prescription drugs*, and all other procedures and equipment developed for or used in the treatment of impotency, and all related diagnostic testing.

Your coverage does not include benefits for extracorporeal **shock wave treatment** for plantar fasciitis and other musculoskeletal conditions.

Your coverage does not include benefits for the following **skilled nursing *facility*** *stays*:

- for senile deterioration;
- for private duty nursing;
- for custodial care;
- *facility* services during a temporary leave of absence from the *facility*; or
- a private room, unless it is *medically necessary*.

Your coverage does not include benefits for the following **spinal manipulation and manual medical therapy services:**

- any treatment or service not authorized by the American Specialty Health Group (ASHG);
- services for examination and/or treatment of strictly non-neuromusculoskeletal disorders, or conjunctive therapy not associated with spinal or joint adjustment;
- manual medical interventions for illnesses or injuries other than musculoskeletal illnesses or injuries;
- laboratory tests, x-rays, adjustments, physical therapy or other services not documented as *medically necessary* and appropriate, or classified as *experimental* or in the research state;
- diagnostic scanning, including magnetic resonance imaging (MRI), CAT scans, and/or other types of diagnostic scanning; thermography;
- educational programs, non-medical self-care or self-help, or any self-help physical exercise training, or any related diagnostic testing;
- air conditioners, air purifiers, therapeutic mattresses, supplies or any other similar devices or appliances;
- vitamins, minerals, nutritional supplements, or any other similar type products; or
- spinal decompression devices. This includes, but is not limited to, Vertebral Axial Decompression (Vax-D) and DRX9000.

T

Your coverage does not include benefits for treatment of congenitally missing, malpositioned, or super numerary **teeth**, even if part of a congenital anomaly, except as stated in this *EOC* or as required by law.

Your coverage does not include benefits for treatment of the **teeth, jawbone or gums** that is required as a result of a medical condition except as expressly required by law or specifically stated as a *covered service.*

Your coverage does not include benefits for dental appliances, for the treatment of **teeth, jawbone or gums,** except as expressly required by law or specifically stated as a *covered service*.

Your coverage does not include benefits for services, supplies, and equipment for the following:

a. Gastric electrical stimulation.
b. Hippotherapy.
c. Intestinal rehabilitation therapy.
d. Prolotherapy.
e. Recreational therapy.
f. Sensory integration therapy (SIT).

Your coverage does not include benefits for **travel costs,** mileage, lodging, meals, and other *member*-related travel costs except as described in this *EOC*.

Your coverage does not include benefits for non-interactive **telemedicine services.** Non-interactive telemedicine services include an audio-only telephone conversation, electronic mail message, facsimile transmission, or online questionnaire.

V

Your coverage does not include benefits for **vision care services** which include:

- Vision care for *members* age 19 and older, unless covered by the medical benefits of this *EOC*.
- For any condition, disease, defect, ailment or injury arising out of and in the course of employment if benefits are available under the Workers' Compensation Act or any similar law. This exclusion applies if a *member* receives the benefits in whole or in part. This exclusion also applies whether or not the *member* claims the benefits or compensation. It also applies whether or not the *member* recovers from any third party.
- To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- For which the *member* has no legal obligation to pay in the absence of this or like coverage.
- Prescribed, ordered or referred by, or received from a *member* of the *member's* immediate family, including the *member's* spouse, child, brother, sister or parent.
- For completion of claim forms or charges for medical records or reports unless otherwise required by law.
- For missed or canceled appointments.
- For which benefits are payable under Medicare Part A and/or Medicare Part B except as specified elsewhere in this booklet or as otherwise prohibited by federal law.
- For services or supplies primarily for educational, vocational or training purposes, except as otherwise specified herein.

- Received from an optical or medical department maintained by or on behalf of a group, mutual benefit association, labor union, trust or similar person or group (unless received by a network *provider*).
- For safety glasses and accompanying frames.
- For *inpatient* or *outpatient hospital* vision care, unless covered by the medical benefits of this *EOC*.
- For orthoptics or vision training and any associated supplemental testing.
- For two pairs of glasses in lieu of bifocals.
- For plano lenses (lenses that have no refractive power).
- For medical or surgical treatment of the eyes, unless covered by the medical benefits of this *EOC*.
- Lost or broken lenses or frames, unless the *member* has reached the *member's* normal interval for service when seeking replacements.
- For services or supplies not specifically listed in this *EOC.*
- Cosmetic lenses or options.
- Blended lenses.
- Oversize lenses.
- For sunglasses.
- For services or supplies combined with any other offer, coupon or in-store advertisement.
- Benefit is not available on certain frame brands in which the manufacturer imposes a no discount policy.
- No benefit is available for frames or contact lenses purchased outside of *our* formulary.
- Routine vision care and materials, except as covered under the Pediatric Vision Care provision, and under Wellness services.
- Vision services or supplies unless needed due to eye surgery or accidental injury.
- Eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis, or excimer laser refractive keratectomy.
- 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.
- Safety glasses accompanying frames of any type.
- Any non-prescription lenses, eyeglasses or contacts.
- Any lost or broken lenses or frames.
- Services needed for employment or given by a medical department, clinic, or similar service provided or maintained by the employer or any government entity.

- Any other vision services not specifically listed as covered.

- For prescription, fitting, or purchase of eye glasses or contact lenses except as otherwise specifically stated as a *covered service*. This exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery, or for soft contact lenses due to a medical condition.

W

Your coverage does not include benefits for any illness or injury that occurs while serving in the armed forces, including as a result of any act of **war**, declared or undeclared. At the *subscriber's* request, *we* will refund any *premiums* paid from the date the *member* enters the military.

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

Your coverage does not include benefits for any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any **Worker's Compensation** Act or other similar law. If Worker's Compensation Act benefits are not available to *you*, then this exclusion does not apply. This exclusion applies if *you* receive the benefits in whole or in part. This exclusion also applies whether or not *you* claim the benefits or compensation. It also applies whether or not *you* recover from any third party.

Claims and Payments

This section describes how *your* claims are administered, explains the cost-sharing features of *your* plan, and outlines other important provisions. The specific cost sharing features, and the applicable benefit percentages and/or limitations, are outlined in *your* **Schedule of Cost Shares and Benefits**.

We consider *covered services* to be incurred on the date a service is provided. This is important because *you* must be actively enrolled on the date the service is provided.

Individual Deductible

The individual *deductible* is the dollar amount that each *member* must satisfy, per calendar year, before *we* pay applicable benefits. The individual *deductible* amount is shown in the **Schedule of Cost Shares and Benefits**.

Family Deductible

If *you* have family members covered under this *EOC*, the family *deductible* amount is the dollar amount that must be satisfied, per calendar year, before *we* pay applicable benefits for all family members. Once two or more covered family members' accumulate individual *deductible* amounts, which combine to equal the family *deductible* amount, then no other individual's *deductible* has to be met for the remainder of the calendar year.

No one covered family member can contribute more than his/her individual *deductible* to the family *deductible*. The family *deductible* amount is shown in the **Schedule of Cost Shares and Benefits**.

Deductible Calculation

The in-network and out-of-network *deductibles* accumulate separately and do not count towards satisfying each other.

The *deductible* applies to most *covered services*, even those with a zero percent *coinsurance*. An example of services not subject to the *deductible* is network *preventive care services* required by law.

Copayments do not count towards satisfying the *deductible*.

Deductible amounts satisfied in a calendar year count towards the *out-of-pocket limit*.

Copayment

Copayment means the fixed dollar amount *you* may be responsible for when *you* visit a *provider* or fill a prescription for covered *prescription drugs* at the retail or mail order *pharmacy*. *Your copayment* responsibility is shown in *your* **Schedule of Cost Shares and Benefits**. *You* may have a *copayment* for certain services when using in-network *providers*. Whether a *copayment* or *coinsurance* applies to a *covered service*, depends on your plan's benefit design.

Copayments satisfied in a calendar year count towards the *out-of-pocket limit*.

Coinsurance

Coinsurance means the percentage of the *maximum allowed amount* for which *you* are responsible for a specified *covered service*. For example, if *your coinsurance* percentage listed on *your* **Schedule of Cost Shares and Benefits** is 20%, *you* are responsible for 20% of the *maximum allowed amount*. See the explanation of *maximum allowed amount* further down in this section for additional information. Whether a *copayment* or *coinsurance* applies to a *covered service* depends on *your* plan's benefit design.

Coinsurance amounts satisfied in a calendar year count towards the *out-of-pocket limit*.

There are no *copayments* for *visits* to out-of-network *providers* or out-of-network retail *pharmacies*. *You* are, however, generally responsible for a higher *coinsurance* amount shown in *your* **Schedule of Cost Shares and Benefits**, after *your* out-of-network *deductible* is met.

Individual Out-of-Pocket Limit

The individual *out-of-pocket limit* is the dollar amount that each *member* must incur in *cost-shares*, per calendar year, before *we* begin to pay one hundred percent (100%) of *covered services* (up to the *maximum allowed amounts*). The individual *out-of-pocket limit* is shown in the **Schedule of Cost Shares and Benefits**.

Family Out-of-Pocket Limit

If *you* have family members covered under this *EOC*, the family *out-of-pocket limit* is the dollar amount that must be incurred in *cost-shares*, per calendar year, before *we* begin to pay one hundred percent (100%) of *covered services* (up to the *maximum allowed amounts*), for all family members. Once two or more covered family members accumulate individual *out-of-pocket limits, which* combine to equal the family *out-of-pocket limit* amount, then no other individual's *out-of-pocket limit* has to be met for the remainder of the calendar year.

No one covered family member can contribute more than his/her individual *out-of-pocket limit* to the family *out-of-pocket limit* amount. The family *out-of-pocket limit* amount is shown in the **Schedule of Cost Shares and Benefits**.

Out-of-Pocket Limit Exceptions

Please read this section very carefully. Not all monies that *you* pay toward *your* health care costs are counted toward *your out-of-pocket limit*.

"*Out-of-pocket limit*" is the maximum dollar amount that *you* pay for *covered services* before *your EOC* covers one hundred percent (100%) of the *maximum allowed amount* for *covered services*. This dollar amount is shown in *your* **Schedule of Cost Shares and Benefits**.

Amounts *you* incur towards *your deductible*, *copayment*s, and/or *coinsurance* count towards the *out-of-pocket limit*. However, the following will never count towards the *out-of-pocket limit*, nor will they ever be paid under this *EOC*:

- amounts exceeding the *maximum allowed amount*;
- amounts over any *EOC* maximum or limitation; and
- expenses for services not covered under this *EOC*

Also, the following is never counted towards the out-of-network, *out-of-pocket limit* and once *your* out-of-network, *out-of-pocket limit* has been met, it is never paid at one hundred percent (100%):

- *coinsurance* for covered out-of-network human organ tissue transplant services.

We will send notification to *you* within 30 days of *your* calendar year *out-of-pocket limit* being met. Any *cost-sharing* paid in excess of the calendar year *out-of-pocket limit*, will be promptly refunded to *you*.

Out-of-Pocket Limit Calculation

The *deductible*, *coinsurance**, and *copayment* amounts incurred in a calendar year apply to the *out-of-pocket limit*.

Once the in-network *out-of-pocket limit* is satisfied, no additional in-network *cost sharing* will be required for the remainder of the calendar year.

Once the out-of-network *out-of-pocket limit* is satisfied, no additional out-of-network *cost sharing* will be required for the remainder of the calendar year, except for *out-of-network* human organ and tissue transplant services.

The in-network and out-of-network *out-of-pocket limits* accumulate separately and do not count towards satisfying each other.

*The out-of-network *out-of pocket limit* does not include *coinsurance* for any out-of-network human organ tissue transplant.

How HealthKeepers Pays a Claim

The *covered services* available under *your EOC* are to be used only by *you* and *your* covered *dependents. You* may not give permission to anyone else (assign *your* right) to receive *covered services* under *your* coverage. *You* may not assign *your* right to receive payment for *covered services.* Prior payments to anyone, whether or not there has been an assignment of payment, shall not constitute a waiver of, or otherwise restrict, *HealthKeepers* right to direct future payments to *you* or any other individual or facility. Notwithstanding any provision in this *EOC* to the contrary, however, *HealthKeepers*:

- will reimburse directly any ambulance service provider to whom the *member* has executed an assignment of benefits; and
- will reimburse an out-of-network *provider* or *facility* directly for medical screening and *stabilization* services which were rendered to meet the requirements of the Federal Emergency Medical Treatment and Active Labor Act.

How *we* pay a claim takes into account the *maximum allowed amount* for the service, the network status of the *provider* or *facility* where *you* receive services, and *your member cost share* under *your EOC*. Each of the components is explained in the sections that follow. For the purposes of these sections, *providers,* also includes *facilities*.

Deductibles, Date of Service, and Claim Filing

We do not always receive claims in the order in which *you* received the services. *We* process claims in the sequence they are received in our office. To determine what monies count toward *your deductible*, *we* look at the date of service on *your* claim form to determine the benefit period which is applicable for the claim.

Maximum Allowed Amount (MAA)

GENERAL

Reimbursement for services rendered by participating and non-participating *providers* is based on this *EOC's maximum allowed amount* for the *covered service* that *you* receive. Please see the "Inter-Plan Arrangements" section of this *subscriber* agreement for additional information.

The *maximum allowed amount* for this plan is the maximum amount of reimbursement *HealthKeepers* will allow for services and supplies:

- that meet *our* definition of *covered services*, to the extent such services and supplies are covered under *your EOC* and are not excluded;
- that are *medically necessary*; and
- that are provided in accordance with all applicable prior authorization, utilization management or other requirements set forth in *your EOC*.

You will be required to pay a portion of the *maximum allowed amount* to the extent *you* have not met *your deductible* or have a *copayment* or *coinsurance*. In addition, when *you* receive *covered services* from a non-participating *provider*, *you* may be responsible for paying any difference between the *maximum allowed amount* and the *provider's* actual charges. This amount can be significant.

When *you* receive *covered services* from a *provider*, *we* will, to the extent applicable, apply claim processing rules to the claim submitted for those *covered services*. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect *our* determination of the *maximum allowed amount*. *Our* application of these rules does not mean that the *covered services you* received were not *medically necessary*. It only means *we* have determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, *your provider* may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the *maximum allowed amount* will be based on the single procedure code rather than a separate *maximum allowed amount* for each billed code.

When multiple procedures are performed on the same day by the same *provider*, or other healthcare professional, *we* may reduce the *maximum allowed amount*s for those secondary and subsequent procedures because reimbursement at 100% of the *maximum allowed amount* for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

PROVIDER NETWORK STATUS

The *maximum allowed amount* may vary depending upon whether the *provider* is a participating *provider* or a non-participating *provider*.

A participating *provider* is a *provider* who is in the managed network for this specific *EOC* or in a special center of excellence/or other closely managed specialty network. For *covered services* performed by a participating *provider*, the *maximum allowed amount* for this plan is the rate the *provider* has agreed with *HealthKeepers* to accept as reimbursement for the *covered services*. Because participating *providers* have agreed to accept the *maximum allowed amount* as payment in full for those *covered services*, they should not send *you* a bill or collect for amounts above the *maximum allowed amount*. However, *you* may receive a bill or be asked to pay all or a portion of the *maximum allowed amount* to the extent *you* have not met *your deductible* or have a *copayment* or *coinsurance*. Please call **Member Services** for help in finding a participating *provider* or visit *our* website at www.anthem.com.

Providers who have not signed any contract with *us* and are not in any of *our* networks are non-participating *providers*, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary *providers*.

For *covered services you* receive from a non-participating *provider* that have been prior authorized by *us*, the *maximum allowed amount* for this plan will be one of the following as determined by *HealthKeepers*:

1) An amount based on *our* non-participating *provider* fee schedule/rate, which *we* have established in *our* discretion, and which *we* reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts for like/similar *providers*, contracted with *HealthKeepers*, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or

2) An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services (“CMS”). When basing the *maximum allowed amount* upon the level or method of reimbursement used by CMS, *HealthKeepers* will update such information, which is unadjusted for geographic locality, no less than annually; or

3) An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable *providers*’ fees and costs to deliver care, or

4) An amount negotiated by *us* or a third party vendor which has been agreed to by the *provider*. This may include rates for services coordinated through case management.

5) An amount based on or derived from the total charges billed by the non-participating *provider*.

Providers who are not contracted for this product, but contracted for other products with *HealthKeepers* are also considered non-participating. For this plan the *maximum allowed amount* reimbursement for services from these *providers* will be one of the five methods shown above unless the contract between *HealthKeepers* and that *provider* specifies a different amount.

Unlike participating *providers*, non-participating *providers* may send *you* a bill and collect for the amount of the *provider's* charge that exceeds *our maximum allowed amount*. *You* are responsible for paying the difference between the *maximum allowed amount* and the amount the *provider* charges. This amount can be significant. Choosing a participating *provider* will likely result in lower out of pocket costs to *you*. Please call **Member Service**s for help in finding a participating *provider* or visit *our* website at www.anthem.com.

Member Services is also available to assist *you* in determining this plan's *maximum allowed amount* for a particular service from a non-participating *provider*. In order for *us* to assist *you*, *you* will need to obtain from *your provider* the specific procedure code(s) and diagnosis code(s) for the services the *provider* will render. *You* will also need to know the *provider's* charges to calculate *your* out-of-pocket responsibility. Although **Member Services** can assist *you* with this pre-service information, the final *maximum allowed amount* for *your* claim will be based on the actual claim submitted.

For *prescription drugs*: The *maximum allowed amount* for *prescription drugs* is the amount determined by *us* using *prescription drug* cost information provided by the Pharmacy benefits manager (PBM).

MEMBER COST SHARE

For certain *covered services* and depending on *your EOC*, *you* may be required to pay a part of the *maximum allowed amount* as *your cost-share* amount (for example, *deductible*, *copayment*, and/or *coinsurance*).

Your cost-share amount and *out-of-pocket maximum limits* may vary depending on whether *you* received services from a participating or non-participating *provider*. Please see the **Schedule of Cost Shares and Benefits** in this *EOC* for *your cost-share* responsibilities and limitations, or call **Member Services** to learn how this *EOC* or *cost-share* amounts may vary by the type of *provider you* use.

We will not provide any reimbursement for non-*covered services*. You will be responsible for the total amount billed by *your provider* for non-*covered services*, regardless of whether such services are performed by a participating or non-participating *provider*. Non-*covered services* include services specifically excluded from coverage by the terms of *your EOC*, and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, *your* day/visit limits

In some instances *you* may only be asked to pay the lower in-network cost-sharing amount when *you* use a non-participating *provider*. For example, if *you* go to a participating hospital or *provider* facility and receive *covered services* from a non-participating *provider* such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with a participating hospital or facility, *you* will pay the participating *cost-share* amounts for those *covered services*. However, *you* also may be liable for the difference between the *maximum allowed amount* and the non-participating *provider's* charge.

Authorized Services

In some non-emergency circumstances, such as where there is no participating *provider* available for the *covered service*, *we* may prior-authorize the network *cost-share* amounts (*deductible*, *copayment*, and/or *coinsurance*) to apply to a claim for a *covered service* you receive from a non-participating *provider*. In such circumstance, *you* must contact *us* in advance of obtaining the *covered service*. *We* also will authorize the participating *cost-share* amounts to apply to a claim for *covered services* if *you* receive emergency services from a non-participating *provider* and are not able to contact *us* until after the *covered service* is rendered. If *we* authorize a network *cost-share* amount to apply to a *covered service* received from an out-of-network *provider*, *you* also may still be liable for the difference between the *maximum allowed amount* and the non-participating *provider's* charge. Please contact **Member Services** for prior authorized services information or to request authorization.

Example:

You require the services of a specialty *provider*; but there is no participating *provider* for that specialty in *your* local network area. *You* contact *us* in advance of receiving any *covered services*, and *we* authorize you to go to an available non-participating *provider* for that *covered service* and *we* agree that the network *cost-share* will apply.

Your plan has a $25 *copayment* for participating *providers* for the *covered service*. The non-participating *provider's* charge for this service is $500. The *maximum allowed amount* is $200.

Because *we* have authorized the participating *cost-share* amount to apply in this situation, *you* will be responsible for the participating *copayment* of $25 and *we* will be responsible for the remaining $175 of the $200 *maximum allowed amount*.

Because the non-participating *provider's* charge for this service is $500, you may receive a bill from the non-participating *provider* for the difference between the $500 charge and the *maximum allowed amount* of $200. Combined with *your* participating *copayment* of $25, *your* total out of pocket expense would be $325.

Non-Participating Providers and Facilities

If *you* go to a non-participating *provider* or facility, *we* may choose to pay *you* or anyone else responsible for paying the bill. *We* will pay only after *we* have received an itemized bill or proof of loss and all the medical information *we* need to process the claim. *We* reserve the right to pay no more for a service *you* receive from a non-participating *provider* or facility than *we* would have paid a participating *provider* or facility for the same service.

In the event that payment is made directly to *you, you* have the responsibility to apply this payment to the claim from the non-participating *provider*. In all cases, *our* payment relieves *us* of any further liability for the service.

Claim Review Process

HealthKeepers has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. *Members* seeking services from out-of network *providers* could be balanced billed by the out-of-network *provider* for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a *provider's* failure to submit medical records with the claims that are under review in these processes.

When You Must File a Claim

Most claims will be filed for *you* by *HealthKeepers providers. You* may have to file a claim if *you* receive care out-of-area from a *provider* who is not a *HealthKeepers provider.* In most cases, *HealthKeepers* will reimburse *you* for *covered services* paid for by *you* only if a completed claim (including receipt) has been received by *us* within 180 days of the date *you* received such services.

If *you* receive *out-of-plan* services, *you* must submit *your* claims within 180 days from the date services are received. Claims will not be processed and will be denied if they are submitted more than 180 days from the date of service, except in the absence of legal capacity of the *member.*

You will have to file a claim if *you* receive care billed by someone other than a doctor or *hospital*, or if the provider cannot file a claim for *you.* To file a claim, follow these 3 steps:

1) Call **Member Services** at the telephone number on *your* identification card to order a claim form.
2) Complete and sign the claim form. Attach all itemized bills for *covered services.* Each itemized bill must contain the following:
    - name and address of the person or organization providing services or supplies;
    - name of the patient receiving services or supplies;

- date services or supplies were provided;
- the charge for each type of service or supply;
- a description of the services or supplies received; and
- a description of the patient's condition (diagnosis).

3) Send the completed claim form and itemized bill(s) to:

HealthKeepers, Inc.
Attention: Operations
P.O. Box 26623
Richmond, VA 23261-6623

When Your Claim is Processed

Once a claim has been processed, if *your* portion of the bill is anything other than zero or equal to a flat *copayment* amount, a paper copy of the Explanation of Benefits (EOB) statement will be mailed to *you* to explain *your* responsibility. In the event that *your* portion of the bill is zero or equal to a flat *copayment* amount, the paper copy will not be mailed, but will available to *you* online at www.anthem.com. If *you* do not have access to the Internet, *you* may contact **Member Services** to arrange for a printed copy.

In processing *your* claim, *we* may use protocols, guidelines or criteria to ensure that coverage determinations are consistently applied. Claims filed as outlined in the "**When You Must File a Claim**" paragraph of this section will be processed within 30 days of receipt of the claim. *We* may extend this period for another 15 days if *we* determine it to be necessary because of matters beyond its control. In the event that this extension is necessary, *you* will be notified prior to the expiration of the initial 30-day period. If the coverage decision involves a determination of the appropriateness or *medical necessity* of services, *we* will make its decision within 2 working days of its receipt of the medical information needed to process the claim.

We may deny a claim for benefits if information needed to fully consider the claim is not provided. The denial will describe the additional information needed to process the claim. The claim may be reopened by *you* or *your provider* furnishing the additional information. *You* or *your provider* must submit the additional information to *us* within either 12 months of the date of service or 45 days from the date *you* were notified that the information is needed, whichever is later. Once *your* claim has been processed by *us, you* will receive written notification of the coverage decision. In the event of an *adverse benefit determination,* the written notification will include the following:

- information sufficient to identify the claim involved;
- the specific reason(s) and the *EOC* provision(s) on which the determination is based;
- a description of any additional material or information necessary to reopen the claim for consideration, along with an explanation of why the requested material or information is needed;
- a description of *our* appeal procedures and applicable time limits; and
- the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist *you* with the internal or external appeals process. If all or part of a claim was not covered, *you* have a right to see, upon request and at no charge, any rule, guideline, protocol or criterion that *we* relied upon in making the coverage decision. If a coverage decision was based on *medical necessity* or the experimental nature of the care, *you* are entitled to receive upon request and at no charge the explanation of the scientific or clinical basis for the decision as it relates to the patient's medical condition.

Recovery of Overpayments

HealthKeepers shall have the right to recover any overpayment of benefits from persons or organizations that *we* have determined to have realized benefits from the overpayment:

- any persons to or for whom such payments were made;
- any insurance company;
- a *facility* or *provider*; or
- any other organization.

You will be required to cooperate with us to secure *our* right to recover the excess payments made on *your* behalf, or on behalf of covered persons enrolled under *your* family coverage. Under certain circumstances, if *we* pay the health care *provider* amounts that are *your* responsibility, such as *deductibles, copayments* or *coinsurance, we* may collect such amounts directly from *you. You* agree that *we* have the right to collect such amounts from *you.*

Payment Innovation Programs

We pay in-network *providers* through various types of contractual arrangements. Some of these arrangements – *payment innovation programs* (*program(s)*) - may include financial incentives to help improve quality of care and promote the delivery of health care services in a cost-efficient manner.

These *programs* may vary in methodology and subject area of focus and may be modified by *us* from time to time, but they will be generally designed to tie a certain portion of an in-network *provider's* total compensation to pre-defined quality, cost, efficiency or service standards or metrics. In some instances, in-network *providers* may be required to make payment to *us* under the *program* as a consequence of failing to meet these pre-defined standards.

The *programs* are not intended to affect *your* access to health care. The *program* payments are not made as payment for specific covered health care services provided to *you*, but instead, are based on the in-network *provider's* achievement of these pre-defined standards. *You* are not responsible for any *copayment* or *coinsurance* amounts related to payments made by *us* or to *us* under the *program(s)*, and *you* do not share in any payments made by in-network providers to *us* under the *program(s).*

Voluntary Clinical Quality Programs

We may offer additional opportunities to assist *you* in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that *you* have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage *you* to get certain care when *you* need it and are separate from *covered services* under *your EOC*. These programs are not guaranteed and could be discontinued at any time. *We* will give *you* the choice and if *you* choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, *you* may receive incentives such as gift cards or retailer coupons, which *we* encourage *you* to use for health and wellness related activities or items. Under other clinical quality programs, *you* may receive a home test kit that allows *you* to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. *You* may also be offered a home visit appointment to collect such specimens and complete biometric screenings. *You* may need to pay any *cost shares* that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee), but will not need to pay for the home test kit or the home visit. (If *you* have any questions about whether receipt of a gift card or retailer coupon results in taxable income to *you*, we recommend that *you* consult *your* tax advisor.)

Value-Added and Incentive Programs

We may offer health or fitness related programs and products to o*ur members*, through which *you* may access discounted rates from certain vendors for products and services available to the general public. *We* may also offer value-added services that include discounts on pharmacy products (over the counter drugs, consultations and biometrics).

In addition, *you* may have access to additional value-added services that include discounts on pet medications, wholesale club memberships, mobile phone minutes and banking and payment services.

The products and services available under this program are not *covered services* under this *EOC* but are in addition to plan benefits and may include giveaways that promote a healthy lifestyle. As such, program features are not guaranteed under *your EOC* and could be discontinued at any time. *We* do not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services *you* receive.

Finally, *we* may offer incentives to *members* who participate in programs that help to reduce administrative expenses or make retaining coverage more convenient. Such programs may include enrolling to automatically pay *premiums* electronically instead of receiving a bill each month.

If You are Covered by More Than One Policy

Coordination With Other Health Care Policies

This provision explains coordination of benefits (COB). This COB provision applies when *you* are covered by more than one health insurance policy. When the COB provision applies, the insurance carriers involved will coordinate the benefits payable. The purpose of the COB provision is to save health care dollars by preventing duplicate payments for the same services.

If *you* have two insurance policies, one of the policies will be considered the primary policy and the other policy will be the secondary policy. The primary policy is the policy which will process claims for benefits first (as though no other coverage exists), and the secondary policy will coordinate its payment so as not to duplicate benefits provided by the primary policy.

Coverage under this *EOC* is always:

- secondary to any group coverage; and
- primary to Medicaid (the Virginia Department of Medical Assistance Services) benefits.

Whenever the benefits under any other coverage are payable without regard to benefits payable under this *EOC*, this *EOC* will be secondary. Services that are not eligible for benefits under both policies will not be subject to coordination of benefits.

When this *EOC* is secondary, the value of *covered services* will be based on *our maximum allowed amount* to determine *our* liability. When providing secondary coverage, the aggregate of benefits under both policies for the coordinated services will not exceed *our maximum allowed amount* for those coordinated services. If benefits are provided in the form of services by the primary carrier, as with a health maintenance organization the value of the coordinate services is based upon *our maximum allowed amount* for the service. *We* may coordinate the benefits *we* would have paid so that the sum of *our* benefits and the value of the coordinated services reduced by any applicable *deductible*, *copayment* or *coinsurance* of the primary carrier does not exceed *our maximum allowed amount*.

No limitations will be extended because of coordination of benefits. All dollar amount and visit limits still apply, even when *we* are the secondary carrier. *You* may not elect to file *your* claims only with *us* in order to obtain primary benefits when the other carrier would otherwise be the primary carrier.

Coordination with insurance policies other than group coverage or Medicaid:

- **Determining Primary Versus Secondary Coverage for the Insured**
  If the *subscriber* of this *EOC* is also the *insured* of another insurance company's individual policy, the longer policy rule applies. This means the policy, which covered the person longer, pays benefits first as the primary carrier. The policy, which covered that person for the shorter time, pays benefits as the secondary carrier. If the two individual policies are effective on the same day, *we* will be the secondary carrier.
  If both *HealthKeepers* and the other insurance carrier claim to be secondary and the other carrier demonstrates its denial of primary responsibility, this *EOC* will be primary.

- **Determining Primary Versus Secondary Coverage for Non-Dependent or Dependent:** The plan that covers the person other than as a *dependent*, for example as an employee, member, policyholder, subscriber or retiree is the primary plan and the plan that covers the person as a *dependent* is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a *dependent*, and primary to the plan covering the person as other than a *dependent* (e.g. a retired employee), then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, policyholder, subscriber or retiree is the secondary plan and the other plan is the primary plan.

- **Dependent Children Dual Coverage and the "Birthday Rule":** When *dependent* children are enrolled and eligible for coverage by another policy, the primary policy will be the policy of the parent whose birthday falls earlier in the calendar year. The month and day are considered, regardless of the birth year. This is termed the "Birthday Rule." For example: Father's birth date is December 9th and Mother's birth date is February 4th. The mother's policy would be primary for the children because her birthday falls first in the calendar year.

- **Dependents of Divorced Parents:** If the parent with custody of the covered children has not remarried, this parent's policy provides primary benefits and the parent without custody provides secondary benefits.

  If the parent with custody has remarried, this parent's policy still provides primary benefits, the stepparent's policy provides secondary benefits, and the parent without custody provides any balance of benefits.

  When there is a divorce decree, which assigns financial responsibility for health care of *dependent* children, the decree will determine who must provide primary benefits for the children.

- **"Longer Policy Rule":** If the primary carrier cannot be determined by the above rules, the policy that has covered the *dependent* longer will be the primary policy.
  Some insurance companies designate a father's policy as the primary policy for children. If *we* must coordinate coverage with a policy that follows this rule, the father's policy will be primary.

Medicare

Any benefits covered under both this *EOC* and Medicare will be paid pursuant to Medicare Secondary Payor legislation, regulations, and Centers for Medicare and Medicaid Services guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among *state* law, *EOC* provisions, and federal law.

Except when federal law requires the plan to be the primary payor, the benefits under this *EOC* for *members* age 65 and older, or *members* otherwise eligible for Medicare, do not duplicate any benefit for which *members* are entitled under Medicare, including Parts B and/or D. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to *members* shall be reimbursed by or on behalf of the *members* to the plan, to the extent the plan has made payment for such services. For the purpose of the calculation of benefits, if the *member* has not enrolled in the Medicare Parts B and/or D, *we* will calculate benefits as if they had enrolled.

Claims Information

Claims which are applicable to the COB provision are subject to the same requirements as any other claim. This information includes but is not limited to the following: a description of the services rendered; the diagnosis; date(s) of service; place of *treatment*; *provider* rendering services; date of accident, if applicable; the charge for each service; and admission review for *inpatient* services.

When this *EOC* is secondary, additional information regarding the other carrier's payment is necessary. Usually this is provided by the other carrier's Explanation of Benefits (EOB) form. This EOB provides the processing information of the other carrier including: the amount applied to the *deductible*; the paid amount; and any denied charges.

Payment Rules and COB Overpayments

When it is known or suspected that other coverage exists, claims cannot be considered for coverage until the other carrier's liability has been investigated. If benefits are later determined to be overpaid, *we* shall have the right to recover the excess amount from the following as *we* determine, in *our* sole discretion, to be appropriate:

- any person to or for whom the payments were made;
- any insurance company; or
- any other organization.

Underpayments

If *your HealthKeepers EOC* is liable, but payments have been made under any other policy, *we* may pay any entity that has paid any amounts *we* determine will meet the intent of this COB provision. Amounts paid to another entity will be considered as benefits provided under this *EOC* and *we* will no longer be liable under *your Healthkeeper's EOC*.

Investigating Other Insurance

From time to time, *you* will be asked to complete a questionnaire about other health care coverage. Please complete and return the questionnaire to *us* quickly. Also, please let *us* know when *your* family's other insurance coverage changes or is canceled. This will help to prevent denial of benefits under this *EOC* for the lack of information.

Eligibility

The benefits, terms and conditions of this *EOC* are applicable to individuals who are determined by the *exchange* to be *qualified individuals* for purposes of enrollment in a *qualified health plan (QHP)*.

Subscriber

To be eligible for membership as a *subscriber* under this *EOC*, the applicant must:

1. Be determined by the *exchange* to be a *qualified individua*l for enrollment in a *QHP*.
2. Be qualified by the *exchange* as eligible, if applying to purchase a catastrophic plan.
3. Be a United States citizen or national; or
4. Be a lawfully present non-citizen for the entire period for which coverage is sought; and
5. Be a resident of the State of Virginia; and meet the following applicable residency standards;

   For a *qualified individual* age 21 and over, the applicant must:

   - Not be living in an institution
   - Be capable of indicating intent
   - Not be receiving optional state supplementary payments (SSP)
   - Reside in the *service area* of the *exchange*

   For a *qualified individual* under age 21, the applicant must:

   - Not be living in an institution
   - Not be eligible for Medicaid based on receipt of federal payments for foster care and adoption assistance under Social Security
   - Not be emancipated
   - Not be receiving optional state supplementary payments (SSP)
   - Reside in the *service area* of the *exchange*

6. Agree to pay for the cost of *premium* that *HealthKeepers* requires;
7. Reveal any coordination of benefits arrangements or other health benefit arrangements for the applicant or *dependents* as they become effective;
8. Not be incarcerated (except pending disposition of charges).
9. Not be entitled to or enrolled in Medicare Parts A/B and/or D;
10. Not be covered by any other group or individual health benefit plan.

For purposes of eligibility, a *qualified individual's service area* is the area in which the *qualified individual*:

1. Resides, intends to reside (including without a fixed address); or
2. Has entered without a job commitment.

For *qualified individuals* under age 21, the *service area* is that of the parent or caretaker with whom the *qualified individual* resides.

For tax households with *members* in multiple *exchange service areas*:

1. If all of the *members* of a tax household are not living within the same *exchange service area*, any *member* of the tax household may enroll in a *qualified health plan* through any of the *exchanges* for which one of the *tax filers* meets the residency requirements.
2. If both spouses in a tax household enroll in a *qualified health plan* through the same *exchange*, a tax *dependent* may only enroll in a *qualified health plan* through that *exchange*, or through the *exchange* that services the area in which the *dependent* meets a residency standard.

Dependents

To be eligible for coverage to enroll as a *dependent*, *you* must be listed on the enrollment form completed by the *subscriber*, be determined by the *exchange* to be a *qualified individual*, meet all *dependent* eligibility criteria established by the *exchange* and be:

1. The *subscriber's* legal spouse.
2. The *subscriber's* Domestic Partner - Domestic partner or domestic partnership means a person of the same or opposite sex for whom all of the following are true: he or she is the *subscriber's* sole domestic partner and has been for twelve (12) months or more; he or she is mentally competent; neither the *subscriber* nor the domestic partner is related in any way (including by adoption or blood) that would prohibit him or her from being married under *state* law; he or she is not married to or separated from anyone else; and he or she is financially interdependent with the *subscriber.*
    a. For purposes of this *EOC*, a domestic partner shall be treated the same as a spouse, and a domestic partner's child, adopted child, or child for whom a domestic partner has legal guardianship shall be treated the same as any other child.
    b. A domestic partner's or a domestic partner's child's coverage ends at the end of the month of the date of dissolution of the domestic partnership.
    c. To apply for coverage as domestic partners, both the *subscriber* and the eligible domestic partner are required to complete and sign an enrollment application, meet all criteria stated on the enrollment application and submit the enrollment application to the *exchange*. The *exchange* will make the ultimate decision in determining eligibility of the domestic partner.
3. The *subscriber's* or the *subscriber's* spouse's children, including stepchildren, newborn, foster children, and legally adopted children, including children placed for adoption, who are under age 26.
4. Children for whom the *subscriber* or the *subscriber's* spouse is a legal guardian and who are under age 26.

Eligibility will be continued past the age limit only for those already enrolled *dependents* who cannot work to support themselves by reason of intellectual or physical disability. These *dependents* must be allowed as a federal tax exemption by the *subscriber* or *subscriber's* spouse. The *dependent's* disability must start before the end of the period he or she would become ineligible for coverage. The *exchange* must certify the *dependent's* eligibility. The *exchange* must be informed of the *dependent's* eligibility for continuation of coverage within 60 days after the date the *dependent* would normally become ineligible. *You* must notify the *exchange* if the *dependent's* tax exemption status changes and if he or she is no longer eligible for continued coverage.

The *exchange* may require the *subscriber* to submit proof of continued eligibility for any enrolled child. *Your* failure to provide this information could result in termination of a child's coverage.

Temporary custody is not sufficient to establish eligibility under this *EOC*.

Open Enrollment

As established by the rules of the *exchange*, *qualified individuals* are only permitted to enroll in a *qualified health plan (QHP)*, or as an enrollee to change *QHPs*, during the annual open enrollment period or a special enrollment period for which the *qualified individual* has experienced a qualifying event.

An annual open enrollment period is provided for *qualified individuals* and enrollees. *Qualified individuals* may enroll in a *QHP*, and enrollees may change *QHPs* at that time according to rules established by the *exchange*.

American Indians are authorized to move from one *QHP* to another *QHP* once per month.

Changes Affecting Eligibility and Special Enrollment

A special enrollment period is a period during which a *qualified individual* or enrollee who experiences certain qualifying events or changes in eligibility may enroll in, or change enrollment in, a *QHP* through the *exchange*, outside of the annual open enrollment period.

Length of special enrollment periods: Unless specifically stated otherwise, a *qualified individual* or enrollee has 60 calendar days from the date of a triggering event to select a *QHP*.

The *exchange* must allow *qualified individuals* and enrollees to enroll in or change from one *QHP* to another as a result of the following triggering events:

- A *qualified individual* or *dependent* loses *minimum essential coverage*;
- A *qualified individual* gains a *dependent* or becomes a *dependent* through marriage, birth, adoption, placement for adoption, or placement in foster care;
- An individual, not previously a citizen, national, or lawfully present gains such status;
- A *qualified individual's* enrollment or non-enrollment in a *QHP* is unintentional, inadvertent, or erroneous and is the result of an error of the *exchange* or HHS, or its instrumentalities as determined by the *exchange*. In such cases, the *exchange* may take such action as may be necessary to correct or eliminate the effects of such error;
- An enrollee demonstrates to the *exchange* that the *QHP* in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;
- An individual is determined newly eligible or newly ineligible for *advance payments of the premium tax credit* or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a *QHP*;
- The *exchange* must permit individuals whose existing coverage through an eligible employer sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming *plan year* to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan;
- A *qualified individual* or enrollee gains access to new *QHPs* as a result of a permanent move; and
- A *qualified individual* or enrollee demonstrates to the *exchange*, in accordance with HHS guidelines, that the individual meets other exceptional circumstances as the *exchange* may provide.

Qualified individuals are free to move between metal levels during special enrollment periods.

Newborn and Adopted Child Coverage

Newborn children of the *subscriber* or the *subscriber's* spouse will be covered for an initial period of 31 days from the date of birth. Coverage for newborns will continue beyond the 31 days, provided the *subscriber* with other than family coverage submits through the *exchange* a form to add the child under the *subscriber's EOC*. The form must be submitted along with the additional *premium*, if applicable, within 60 days after the birth of the child.

A child will be considered adopted from the earlier of: (1) the moment of placement for adoption; or (2) the date of an entry of an order granting custody of the child to *you*. The child will continue to be considered adopted unless the child is removed from *your* home prior to issuance of a legal decree of adoption.

Adding a Child due to Award of Legal Custody or Guardianship

If a *subscriber* or the *subscriber's* spouse files an application for appointment of guardianship for a child, an application to cover the child under the *subscriber's EOC* must be submitted to the *exchange* within 60 days of the date the appointment of guardianship is granted. Coverage will be effective on the date the appointment of guardianship is awarded by the court.

Qualified Medical Child Support Order

If *you* are required by a qualified medical child support order or court order, as defined by applicable *state* or federal law, to enroll *your* child under this *EOC*, and the child is otherwise eligible for the coverage, *you* must request permission from the *exchange* for *your* child to enroll under this *EOC*, and once approved by the *exchange*, *we* will provide the benefits of this *EOC* in accordance with the applicable requirements of such order.

A child's coverage under this provision will not extend beyond any *dependent* age limit. Any claims payable under this *EOC* will be paid, at *our* discretion, to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. *We* will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to us directly.

Effective Date of Coverage

The earliest *effective date* for the annual open enrollment period is the first day of the following *benefit year* for a *qualified individual* who has made a *QHP* selection during the annual open enrollment period. A *subscriber's* actual *effective date* is determined by the date he or she submits a complete application and the applicable *premium* to the *exchange*.

Effective dates for special enrollment periods:

1. In the case of birth, adoption, placement for adoption, or placement in foster care, coverage is effective on the date of birth, adoption, placement for adoption, or placement in foster care. *Advance payments of the premium tax credit* and cost-sharing reductions, if applicable, are not effective until the first day of the following month, unless the birth, adoption, placement for adoption or placement in foster care occurs on the first day of the month; and
2. In the case of marriage, or in the case where a *qualified individual* loses *minimum essential coverage*, coverage is effective on the first day of the month following the event, as long as the application is received within 30 days of the event.

Effective dates for loss of *minimum essential coverage* includes loss of eligibility for coverage as a result of:

1. Legal separation or divorce;
2. Cessation of *dependent* status, such as attaining the maximum age;
3. Death of an employee;
4. Termination of employment;
5. Reduction in the number of hours of employment; or
6. Any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
    - Individual who no longer resides, lives or works in plan's *service area*,
    - A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual,
    - Termination of employer contributions, and
    - Exhaustion of COBRA benefits.

Effective dates for loss of *minimum essential coverage* does not include termination or loss due to:

1. Failure to pay *premiums* on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or
2. Situations allowing for a rescission such as fraud or intentional misrepresentation of material fact.

Notice of Changes

The *subscriber* is responsible to notify the *exchange* of any changes that will affect his or her eligibility or that of *dependents* for services or benefits under this *EOC*. The *exchange* must be notified of any changes as soon as possible but no later than within 60 days of the event. This includes changes in address, marriage, divorce, death, change of *dependent* disability or dependency status. Failure to notify

the *exchange* of persons no longer eligible for services will not obligate *us* to pay for such services. Acceptance of *premium* for persons no longer eligible for services will not obligate *us* to pay for such services.

Family coverage should be changed to single coverage when only the *subscriber* is eligible. When notice is provided within 60 days of the event, the *effective date* of coverage is the event date causing the change to single coverage. The *exchange* must be notified when a *member* becomes eligible for Medicare.

All notifications must be in writing and on approved forms or as otherwise required by the *exchange*. Such notifications must include all information required to effect the necessary changes.

Termination

This section describes how coverage for a *member* can be terminated, cancelled, rescinded, suspended or not renewed.

Termination of the Member

Unless prohibited by law, the *member*'s coverage will terminate if any of the following occurs:

1. The *member* terminates his/her coverage with appropriate notice to the *exchange.*
2. The *member* no longer meets eligibility requirements for coverage in a *QHP* through the *exchange* (examples: divorce, dissolution of domestic partnership, overage *dependent*, move outside the service are, etc…). In this case, the *exchange* will send a notice to the *member*. Coverage ends on the last day of the month following the month in which the *exchange* notifies the *member* (unless the *member* requests an earlier termination date).
3. The *member* fails to pay his/her *premium*, and the grace period has been exhausted.
4. Rescission of the *member*'s coverage.
5. The *QHP* terminates or is decertified.
6. The *member* changes to another *QHP*; or
7. The *QHP* may terminate coverage as permitted by the *exchange*. The *member* will be notified by the *QHP* as required by law.

"Grace Period" refers to either:

1. The 3-month grace period required for individuals receiving *advance payments of the premium tax credit*; in this case, the last day of coverage will be the last day of the first month of the 3-month grace period; or
2. Any other grace period.

Effective Dates of Termination

Termination of coverage is effective on the following date(s):

1. In the case of termination initiated by the *member*, the last day of coverage is:
    a) The termination date specified by the *member*, if reasonable notice is provided;
    b) Fourteen days after the termination is requested, if the *member* does not provide reasonable notice; or
    c) On a date determined by the *member*'s *QHP* issuer, if the *member*'s *QHP* issuer is able to implement termination in fewer than fourteen days and the *member* requests an earlier termination effective date.
2. If the *member* is newly eligible for Medicaid, CHIP, or the Basic Health Plan, the last day of coverage is the day before such coverage begins.
3. In the case where a *member* is no longer eligible for coverage in a *QHP* through the *exchange* (examples: divorce, dissolution of domestic partnership, overage *dependent*, move outside the *service area* etc…), the last day of coverage is the last day of the month following the month in which notice is sent by the *exchange*, unless the individual requests an earlier termination effective date.
4. In the case of a termination for non-payment of *premium* and the 3-month grace period required for individuals receiving *advance payments of the premium tax credit* has been exhausted, the last day of coverage will be the last day of the first month of the 3-month grace period.
5. In the case of a termination for non-payment of *premium*, and the individual is not receiving *advance payments of premium tax credit*, the last day of coverage is the last day of the grace period.
6. In the case of a termination when a *member* changes *QHPs*, the last day of coverage in a *member*'s prior *QHP* is the day before the *effective date* of coverage in his or her new *QHP*.
7. The day following the *subscriber's* death. When a *subscriber* dies, the surviving spouse or domestic partner of the deceased *subscriber*, if covered under the *EOC*, shall become the *subscriber*.

"Reasonable notice" is defined as fourteen days prior to the requested *effective date* of termination.

Guaranteed Renewable

Coverage under this *EOC* is guaranteed renewable, except as permitted to be terminated, canceled, rescinded, or not renewed under applicable *state* and federal law provided the *member* is a *qualified individual* as determined by the *exchange*. The *member* may renew this *EOC* by payment of the renewal *premium* by the end of the grace period of the *premium* due date, provided the following requirements are satisfied:

1. Eligibility criteria, as a *qualified individual,* continues to be met;
2. There are no fraudulent or intentional misrepresentations of material facts on the application or under the terms of this *EOC*; and
3. This *EOC* has not been terminated by the *exchange*.

Loss of Eligibility

Coverage ends for a *member* when he or she no longer meets the eligibility requirements for coverage. *You* must timely furnish to the *exchange* or the *QHP* any information requested regarding *your* eligibility and the eligibility of *your dependents*. Failure to give timely notification of a loss of eligibility will not obligate *us* to provide benefits for ineligible persons, even if *we* have accepted *premiums* or paid benefits.

Rescission

If within two (2) years after the *effective date* of this *EOC*, *we* discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that *you* or *your* covered *dependents* did not disclose on the application, *we* may terminate or rescind this *EOC* as of the original *effective date*. Additionally, if within two (2) years after adding an additional *dependent* (excluding newborn children of the *subscriber* added within 31 days of birth), *we* discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that *you* or *your* covered *dependents* did not disclose on the application, *we* may terminate or rescind coverage for the additional covered *dependent* as of his or her original *effective date*. *We* will give *you* at least 30 days written notice prior to rescission of this *EOC*.

This *EOC* may also be terminated if *you* engage in fraudulent conduct, furnish *us* fraudulent or misleading material information relating to claims or if *you* knowingly participate in or permit fraud or deception by any *provider*, vendor or any other person associated with this *EOC*. Termination will be effective 31 days after *our* notice of termination is mailed. *We* will also terminate *your dependent's* coverage, effective on the date *your* coverage is terminated.

If *your* coverage is rescinded, all *premiums* will be refunded less any claims paid, and will be determined based on the date coverage is being rescinded. *You* are responsible to pay *us* for the cost of previously received services based on the *maximum allowed amount* for such services, less any *copayment/coinsurance* made or *premium* paid for such services. After the two (2) years following *your effective date*, *we* may only rescind or terminate *your* coverage on the basis of any act, practice or omission that constitutes fraud.

Discontinuation of Coverage

We can refuse to renew *your EOC* if *we* decide to discontinue a health coverage product that *we* offer in the individual market. If *we* discontinue a health coverage product, *we* will provide *you* with at least 90 days notice of the discontinuation. In addition, *you* will be given the option to purchase any health coverage plan that *we* currently offer without regard to claims status or health history. Nonrenewal will not affect an existing claim.

Grace Period

If the *subscriber* does not pay the full amount of the *premium* by the *premium* due date, the grace period is triggered. The grace period is an additional period of time during which coverage remains in effect and refers to either the 3-month grace period required for individuals receiving *advance payments of the*

premium tax credit (APTC), or for individuals not receiving the *APTC*; it refers to any other applicable grace period.

If the *subscriber* does not pay the required *premium* by the end of the grace period, the *EOC* is terminated. The application of the grace period to claims is based on the date of service and not on the date the claim was submitted.

Subscriber Receives APTC

If the *subscriber* receiving the *APTC* has previously paid at least one month's *premium* in a b*enefit year*, *we* must provide a grace period of at least three consecutive months. During the grace period, *we* must apply any payment received to the first billing cycle in which payment was delinquent and continue to collect the *APTC*. If full *premium* payment is not received during the grace period, the last day of coverage will be the last day of the first month, of the 3-month grace period.

We must pay claims during the first month of the grace period but may pend claims in the second and third months subject to *our* right to terminate the *EOC* as provided herein. *You* will be liable to *us* for the *premium* payment due including those for the grace period. *You* will also be liable to *us* for any claims payments made for services incurred after the last day of the first month of the 3-month grace period.

Subscriber Does Not Receive APTC

If the *subscriber* is not receiving an *APTC*, this *EOC* has a grace period of 31 days. This means if any *premium* payment, except the first, is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, the *EOC* will stay in force unless prior to the date *premium* payment is due, *you* give timely written notice to *us* that the *EOC* is to be terminated. If *you* do not make the full *premium* payment during the grace period, the *EOC* will be terminated on the last day of the grace period. *You* will be liable to *us* for the *premium* payment due including those for the grace period. *You* will also be liable to *us* for any claims payments made for services incurred after the last day of the grace period.

After Termination

Once this *EOC* is terminated, the former *members* cannot reapply until the next annual open enrollment period unless they experience an event that qualifies for a special enrollment period prior to the annual open enrollment period.

Removal of Members

A *subscriber* may terminate the enrollment of any *member* from the *EOC*. If this happens, no benefits will be provided for *covered services* provided after the *member's* termination date.

Important Information About Your Coverage

In the event *you* need to contact someone about this coverage for any reason please contact *your* agent. If no agent was involved in the sale of this health maintenance organization coverage, or if *you* have any additional questions you may contact *HealthKeepers*, Inc. at the address below or at the telephone number on *your* identification card.

Address:

HealthKeepers, Inc.
Attention: Member Services
P.O. Box 26623
Richmond, VA 23261-6623

Written correspondence is preferable so that a record of *your* inquiry is maintained. When contacting *your* agent, *HealthKeepers,* Inc., or the Bureau of Insurance, have *your EOC* number ready.

We recommend that *you* familiarize yourself with *our* grievance procedure, and make use of it before taking any other actions.

Claims and Member Service

For information and assistance, a *member* may call or write to *us*. The telephone number for **Member Services** is printed on the *member's* identification card.

You may visit *our* home office during normal business hours Monday through Friday – 8:00 a.m. to 5:00 p.m. at:

2015 Staples Mill Road
Richmond, VA 23230

Telephone: (804) 354-7000

Statements and Forms

Subscribers or applicants for membership shall complete and submit to the Exchange applications or other forms or statements the Exchange may request. *Subscribers* or applicants for membership represent to the best of their knowledge and belief that all information contained in such applications, questionnaires, forms, or statements submitted to the Exchange is true, correct, and complete. *Subscribers* and applicants for membership understand that all rights to benefits under this *EOC* are subject to the condition that all such information is true, correct and complete. Any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact by a *member* may result in termination or rescission of coverage.

Your Premium and Where You Live

The *premium you* pay for this coverage is based on many factors, including where *you* live. If *you* move to a new address, *your premium* may increase, decrease, or stay the same. When *you* notify *us* of *your* new address, any *premium* change will be effective on the first of the month following *your* move.

Administrative Fee

An administrative fee of $20 will be charged for any check, automatic deduction, or Electronic Funds Transfer which is returned or dishonored by the financial institution as non-payable to *us* for any reason.

Changes in Premiums

The *premium* rates are guaranteed for the twelve (12) month period following the first day of the *benefit year*. The *premium* for this *EOC* may change subject to, and as permitted by, applicable law. *You* will be

notified of a *premium* change at the address in *our* records, seventy-five (75) days in advance. Any such change will apply to *premiums* due on or after the *effective date* of change. If advance *premiums* have been paid beyond the *effective date* of a rate change, such *premiums* will be adjusted as of that *effective date* to comply with the rate change. Additional *premiums* may be billed, if necessary, for future periods.

Policies and Procedures

We may adopt policies, procedures, rules, and interpretations to promote orderly and efficient administration of coverage under this *EOC.* Any provision, term, benefit, or condition of coverage and this *EOC* may be amended, revised, or deleted by *us* upon thirty-one (31) days written notice, except for *deductible* increases. *You* will be notified of a *deductible* increase seventy-five (75) days in advance of the change. No change in the *EOC* shall be valid unless evidenced by an amendment which is signed by an authorized officer of *HealthKeepers*.

Notices

From HealthKeepers to You

A notice sent to *you* by *us* is considered "given" when mailed to the *subscriber's* last known address as shown in *our* enrollment records. Notices include any information which *we* may send *you*, including identification cards.

From You to HealthKeepers

Notice by *you* is considered "given" when actually received by *us*. *We* will not be able to act on this notice unless *your* name and identification number are included in the notice.

Complaint and Appeal Process

In order for *us* to remain responsive to *your* needs, *we* have established both a complaint process and an appeal process. Should *you* have a problem or question; a **Member Services** representative can assist *you*. Most problems and questions can be handled in this manner. *You* may contact **Member Services** at the telephone number on *your* identification card. *You* may also file a written complaint or appeal with *us*. Complaints typically involve issues such as dissatisfaction about *our* services, quality of care, the choice of and accessibility to *HealthKeepers providers* and network adequacy. Appeals typically involve a request to reverse a previous decision made by *HealthKeepers.* Requests regarding claim errors, claim corrections, and claims denied for additional information may be reopened for consideration without having to invoke the appeal process.

Please refer to the "Prescription Drugs" provision labeled "Prescription Drug List" in the "What Is Covered" section of the *EOC* for the process for submitting an exception request for *drugs* not on the *prescription drug* list.

Complaint Process

Upon receipt, *your* complaint will be reviewed and investigated. *You* will receive a response within 30 calendar days of *our* receipt of *your* complaint. If *we* are is unable to resolve *your* complaint in 30 calendar days, *you* will be notified on or before calendar day 30 that more time is required to resolve *your* complaint. *We* will then respond to *you* within an additional 30 calendar days. Written complaints may be filed to the following address:

HealthKeepers, Inc.
Attention: Member Services
P.O. Box 26623
Richmond, VA 23261-6623

Appeal Process

HealthKeepers is committed to providing a full and fair process for resolving disputes and responding to requests to reconsider coverage decisions *you* find unacceptable, whether the decision is a claim denial or a rescission of coverage. A rescission is a retroactive termination of coverage, other than when it is attributable to a failure to timely pay required *premiums* or contributions towards the cost of coverage. Types of appeals include:

- internal appeals are requests to reconsider rescissions or coverage decisions of *pre-service* or *post-service claims.* Expedited appeals are made available when the application of the time period for making *pre-service* or *post-service* appeal decisions could seriously jeopardize the patient's life, health or ability to regain maximum function, or in the opinion of the patient's physician, would subject the patient to severe pain that cannot be adequately managed without the care or treatment. Situations in which expedited appeals are available include those involving prescriptions to alleviate cancer pain, when the cancer patient would be subjected to pain; and
- external reviews are requests for an independent, external review of coverage decisions made by *HealthKeepers* through its internal appeal process. More information about this type of appeal may be found in the **"Independent external review of adverse utilization review decisions"** paragraph of this section.

How to Appeal a Coverage Decision

To appeal a coverage decision (including a rescission), please send a written explanation of why *you* feel the coverage decision was incorrect. *You* or *your* authorized representative acting on *your* behalf may submit the written explanation. Alternatively, this information may be provided to a **Member Services** representative over the phone. This is *your* opportunity to provide any comments, documents or information that *you* feel *HealthKeepers* should consider when reviewing *your* appeal. Please include with the explanation:

- the patient's name, address and telephone number;
- *your* identification and group number (as shown on *your* identification card); and
- in the case of a claim, the name of the health care professional or *facility* that provided the service, including the date and description of the service provided and the charge.

You may contact **Member Services** with *your* appeal at the address below or at the telephone number on *your member* identification card.

Addresses:

Medical Claims:
HealthKeepers, Inc.
Attention: Corporate Appeals Department
P.O. Box 27401
Richmond, VA 23279

Dental Claims:
HealthKeepers, Inc.
Attention: Appeals Department
P.O. Box 1122
Minneapolis, MN 55440-1122

Vision Claims:
Blue View Vision
Attention: Appeals Department
555 Middle Creek Parkway
Colorado Springs, CO 80921

You must file *your* appeal within either 15 months of the date of service or 180 days of the date *you* were notified of the *adverse benefit determination,* whichever is later.

How HealthKeepers Will Handle Your Appeal

In reviewing *your* appeal, *we* will take into account all the information *you* submit; regardless of whether the information was considered at the time the initial coverage decision was made. A new review will be completed, and will not assume the correctness of the original determination. The individual reviewing *your* appeal will not have participated in the original coverage decision, and will not be a subordinate of the individual who made the original determination. Appeals involving *medical necessity* will be reviewed by a practitioner who holds a non-restricted license in the Commonwealth of Virginia or under comparable licensing law in the same or similar specialty as typically manages the medical condition, procedure or treatment under review. Any other decision that involves the review of medical information will be made by appropriate clinical staff.

We will promptly acknowledge receipt of *your* appeal, and will resolve and respond to it as follows:

- For *pre-service claims*, *we* will respond in writing within 30 days after receipt of the request to appeal;
- For *post-service claims* and rescissions, *we* will respond in writing within 60 days after receipt of the request to appeal; or
- For expedited appeals, *we* will respond to *you* and *your provider* as soon as possible taking into account *your* medical condition, but not later than 72 hours from receipt of the request. *We* will also provide *you,* free of charge, with any new or additional evidence considered, relied upon, or generated in connection with *your* claim. In addition, before *you* receive an *adverse benefit determination* based on new or additional rationale, *we* will provide *you,* free of charge, with the rationale.

When *our* review of *your* appeal has been completed, *you* will receive written notification of the outcome. In the event that the original coverage decision is upheld, the written notification will include the specific reasons and the *EOC* provision(s) on which the determination is based. *You* will also be entitled to receive, upon request and at no charge, the following:

- reasonable access to, and copies of, all documents, records, and other information relevant to the appeal;
- any rule, guideline, protocol or criterion relied upon in the coverage decision(s);
- the explanation of the scientific or clinical judgment as it relates to the patient's medical condition if the coverage decision was based on the *medical necessity* or *experimental* nature of the care; and
- the identification of medical or vocational experts whose advice was obtained by the plan in connection with the claimant's adverse decision, whether or not the advice was relied upon.

If *we* deny *your* appeal, *you* may request an external review through the agency described below.

Independent External Review of Adverse Utilization Review Decisions

If *we* have denied *your* claim, *you* may have the right to request an independent external review of *our* decision by health care professionals who have no association with *us* if our decision involved making a

judgment as to the *medical necessity*, appropriateness, health care setting, level of care, or effectiveness of the health care service or treatment *you* requested (including whether the service or treatment was determined to be *experimental or investigative*). Except when an expedited external review is warranted as described below, the external review process is available only if the denial is upheld after *you* file an internal appeal with *us*. This is called a standard external review.

You or *your* authorized representative may request an expedited external review with the Bureau of Insurance at the same time as exercising *our* expedited appeal process. An expedited external review may also be requested if *our* adverse decision was based upon *our* judgment that the services rendered were *experimental or investigative* and *your* treating physician certifies, in writing, that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated.

If *you* have not already requested an expedited external review in advance of *our* decision to deny *your* claim on appeal, *you* may do so after *our* appeal decision if:

- *you* have a medical condition where the time frame for completion of a standard external review would seriously jeopardize *your* life, health or ability to regain maximum function;
- this decision concerns an admission, availability of care, continued *stay*, or health care service for which you received *emergency* services, but have not been discharged from a *facility*; or
- this decision is based on *our* judgment that the services rendered were *experimental or investigative* and *your* treating physician certifies, in writing, that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated.

To request a standard or expedited external review with the Bureau of Insurance you may contact the Corporate Appeals department listed above, or contact the Bureau of Insurance directly at: Bureau of Insurance – External Review P.O. Box 1157 Richmond VA 23218, Telephone: 877-310-6560, E-Mail:externalreview@scc.virginia.gov

Virginia Bureau of Insurance

If *you* have been unable to contact or obtain satisfaction from *HealthKeepers, you* may contact the Virginia Bureau of Insurance, 1300 East Main Street, P. O. Box 1157, Richmond, VA 23218, in Richmond 804-371-9741, from outside Richmond 800-552-7945, national toll-free number 877-310-6560.

The Office of the Managed Care Ombudsman

If *you* have any questions regarding an appeal or grievance concerning the health care services that *you* have been provided which have not been satisfactorily addressed by *HealthKeepers, you* may contact the Office of the Managed Care Ombudsman for assistance at any of the following:

Address:

The Office of the Managed Care Ombudsman Bureau of Insurance

P.O. Box 1157

Richmond, VA 23218

Telephone:

804-371-9032 in Richmond

877-310-6560 from outside Richmond

E-Mail:

ombudsman@scc.virginia.gov

Web Page:

Information regarding the Ombudsman may be found by accessing the State Corporation Commission's web page at: http://www.scc.virginia.gov

The Virginia Department of Health Office of Licensure and Certification

If *you* have any questions regarding an appeal or grievance concerning the health care services that *you* have been provided which have not been satisfactorily addressed by *HealthKeepers, you* may contact the Virginia Department of Health Office of Licensure and Certification for assistance at any of the following:

Address: Office of Licensure and Certification Virginia Department of Health 9960 Mayland Drive, Suite 401 Richmond, VA 23233

Telephone: Complaint Hotline: 800-955-1819 Richmond Metropolitan Area: 804-367-2106

Fax: 804-527-4502

E-Mail: mchip@vdh.virginia.gov

Limitations of Damages

In the event a *member* or his representative sues *HealthKeepers,* or any of its directors, officers, or employees acting in his or her capacity as director, officer, or employee, for a determination of what coverage and/or benefits, if any, exist under this *EOC,* the damages shall be limited to the amount of the *member's* claim for benefits. The damages shall not exceed the amount of any claim not properly paid as of the time the lawsuit is filed. This *EOC* does not provide coverage for punitive damages, or damages for emotional distress or mental anguish; provided, however, this provision is not intended, and shall not be construed, to affect in any manner any recovery by a *member* or his representative of any non-contractual damages to which a *member* or his representative may otherwise be entitled.

Time Limits on Legal Action

No action at law or suit in equity shall be brought against *HealthKeepers* more than one year after the date the cause of action first accrued with respect to any matter relating to:

- this *EOC;*
- *HealthKeepers'* performance under this *EOC;* or
- any statements made by an employee, officer, or director of *HealthKeepers* concerning the *EOC* or the benefits available.

The cause of action shall be deemed to have accrued 180 days after *HealthKeepers'* initial decision if *you* do not initiate an appeal pursuant to *HealthKeepers'* appeal process or an independent external review of an adverse utilization review decision through the Bureau of Insurance. Otherwise, the cause of action will be deemed to have accrued after the final decision of *HealthKeepers* or Bureau of Insurance external review process.

HealthKeepers Continuing Rights

On occasion, *we* may not insist on *your* strict performance of all terms of this *EOC.* This does not mean *we* waive or give up any future rights *we* have under this *EOC.*

Laws Governing HealthKeepers

HealthKeepers is subject to the laws of the Commonwealth of Virginia.

This coverage is a Managed Care Health Insurance Program subject to regulation in the Commonwealth of Virginia by both the Virginia State Corporation Commission's Bureau of Insurance pursuant to Title 38.2 and the Virginia Department of Health pursuant to Title 32.1.

Relationship of Parties (HealthKeepers and In-network Providers)

The relationship between *HealthKeepers* and in-network *providers* is an independent contractor relationship. In-network *providers* are not agents or employees of *ours*, nor is *HealthKeepers* or any employee of *HealthKeepers*, an employee or agent of in-network *providers*.

Your health care *provider* is solely responsible for all decisions regarding your care and treatment, regardless of whether such care and treatment is a *covered service* under this *EOC*. *We* shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by *you* while receiving care from any in-network *provider* or for any injuries suffered by *you* while receiving care from any in-network *provider's facilities*.

Your in-network *provider's* agreement for providing *covered services* may include financial incentives or risk sharing relationships related to the provision of services or referrals to other *providers*, including in-network *providers*, out-of-network *providers*, and disease management programs. If *you* have questions regarding such incentives or risk sharing relationships, please contact *your provider* or *us*.

Special Limitations

The rights of *members* and obligations of the *HealthKeepers* are subject to the following special limitations: To the extent that a natural disaster, war, riot, civil insurrection, epidemic, or any other emergency or similar event not within the control of *HealthKeepers* results in the facilities, personnel, or financial resources of *HealthKeepers* being unavailable to provide or arrange for the provision of *covered services, HealthKeepers* shall make a good faith effort to provide or arrange for the provision of such health services taking into account the impact of the event. In such an event, *HealthKeepers* and *HealthKeepers' providers* shall render covered hospital and medical services insofar as practical, and according to their best judgment. *HealthKeepers* and *HealthKeepers' providers* shall incur no liability or obligation for delay, or failure to provide or arrange for health services if such failure or delay is caused by such an event.

Incontestability

We can immediately cancel this *EOC* back to the *effective date* during the first two years after the *effective date* if *you* did not tell *us* the truth about information on *your* application and such information was material to our decision to issue this policy to *you*. If we paid claims during this time on *your* behalf, *we* have the right to recover from *you* the amount *we* paid.

Entire Contract

This *Evidence of Coverage* and the individual application of the *subscriber* and *dependents* covered hereunder, as well as any amendments thereto, shall constitute the entire contract between the parties as of the *effective date* hereof and shall supersede all other prior agreements between the parties. No portion of the charter, bylaws or other documents of *HealthKeepers* shall constitute part of the contract between the parties unless set forth in this *EOC*.

Medical Policy and Technology Assessment

HealthKeepers reviews and evaluates new technology according to its technology evaluation criteria developed by its *medical directors*. Technology assessment criteria are used to determine the *experimental/investigational* status or *medical necessity* of new technology. Guidance and external

validation of *HealthKeepers'* medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 doctors from various medical specialties including *HealthKeepers' medical directors*, doctors in academic medicine and doctors in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to *medical necessity* criteria used to determine whether a procedure, service, supply or equipment is covered.

Your Rights and Responsibilities

As a *member*, *you* have rights and responsibilities when receiving health care. As *your* health care partner, *we* want to make sure *your* rights are respected while providing *your* health benefits. That means giving *you* access to our network of health care *providers* and the information *you* need to make the best decisions for *your* health. As a *member*, *you* should also take an active role in *your* care.

***You* have the right to:**

- Speak freely and privately with *your* health care *providers* about all health care options and treatment needed for *your* condition, no matter what the cost or whether it is covered under *your* plan.
- Work with *your* doctors to make choices about *your* health care.
- Be treated with respect and dignity.
- Expect *us* to keep *your* personal health information private by following our privacy policies, and *state* and Federal laws.
- Get the information *you* need to help make sure *you* get the most from *your* health plan, and share *your* feedback. This includes information on:
    - our company and services.
    - our network of health care *providers* .
    - *your* rights and responsibilities.
    - the rules of *your EOC*.
    - the way *your EOC* works.
- Make a complaint or file an appeal about:
    - *your* health plan and any care you receive.
    - any *covered service* or benefit decision that *your* health plan makes.
- Say no to care, for any condition, sickness or disease, without it having an effect on any care *you* may get in the future. This includes asking *your* doctor to tell *you* how that may affect *your* health now and in the future.
- Get the most up-to-date information from a health care *provider* about the cause of *your* illness, *your* treatment and what may result from it. *You* can ask for help if *you* do not understand this information.

***You* have the responsibility to:**

- Read all information about *your* health benefits and ask for help if *you* have questions.
- Follow all *EOC* rules and policies.
- Choose an In-network *primary care physician*, also called a *PCP*, if *your* health plan requires it.
- Treat all doctors, health care *providers* and staff with respect.
- Keep all scheduled appointments. Call *your* health care *provider's* office if *you* may be late or need to cancel.
- Understand *your* health problems as well as *you* can and work with *your* health care *providers* to make a treatment plan that *you* all agree on.
- Inform *your* health care *providers* if *you* don't understand any type of care you're getting or what they want *you* to do as part of *your* care plan.

- Follow the health care plan that *you* have agreed on with *your* health care *providers*.
- Give *us*, *your* doctors and other health care *providers* the information needed to help *you* get the best possible care and all the benefits *you* are eligible for under *your EOC*. This may include information about other health insurance benefits *you* have along with *your* coverage with *us*.
- Inform Member Services if *you* have any changes to *your* name, address or family members covered under *your EOC*.

If *you* would like more information, have comments, or would like to contact *us*, please go to www.anthem.com and select Customer Support > Contact Us. Or call the **Member Services** number on *your* ID card.

We want to provide high quality benefits and customer service to our *members*. Benefits and coverage for services given under the plan are overseen by *your EOC*, *member* handbook or **Schedule of Cost Shares and Benefits**, not by this *member* rights and responsibilities statement.

Definitions

Activities of Daily Living

are walking, eating, drinking, dressing, toileting, transferring (e.g. wheelchair to bed), and bathing.

Advance Payments of the Premium Tax Credit (APTC):

is payment of the tax credits which are provided on an advance basis to an eligible individual enrolled in a *Qualified Health Plan (QHP)* through an *Exchange*.

Adverse Benefit Determination

is any denial, reduction of a benefit or failure to provide a benefit, in whole or in part, by *HealthKeepers*.

American Indian

is an individual who is a member of a Federally Recognized Indian tribe. A tribe is defined as any Indian tribe, band, nation, or other organized group or community, including any Alaska native village or regional or village corporation which is recognized as eligible for the special programs and services provided by the United States because of their status as Indians.

Benefit Year

is a calendar year for which a health plan provides coverage for health benefits.

Brand Name Drugs

are *prescription drugs* that the PBM (Pharmacy Benefits Manager) has classified as *brand name drugs* through use of an independent proprietary industry database.

Clinical Trial

is an organized, systematic, scientific study of therapies, tests or other clinical interventions for purposes of treatment or palliation or therapeutic intervention for the prevention of cancer or disabling or life-threatening chronic disease in human beings.

Coinsurance

is the percentage of the *maximum allowed amount* that you pay for some *covered services*.

Copayment

is a fixed amount (for example, $15) *you* pay for a *covered service*, usually when *you* receive the service. The amount can vary by the type of *covered service*. The *copayment* does not apply to the *deductible*.

Cost-Share (Cost-Sharing)

is the amount which the *member* is required to pay for *covered services*. Where applicable, *cost-shares* can be in the form of *copayments*, *coinsurance*, and/or *deductibles*.

Covered Services

are those *medically necessary* hospital and medical services which are described as covered in this *EOC* and which are performed, prescribed or directed by a physician.

Deductible

is the amount of charges *you* must pay for any *covered services* and *prescription drugs* before any benefits are available to *you* under this coverage. *Your deductible* is stated in *your* **Schedule of Cost Shares and Benefits**.

Dentally Necessary Orthodontic Care

A service for pediatric *members* used to treat malocclusion of teeth and associated dental and facial disharmonies. Certain criteria must be met in order for *dentally necessary orthodontic care* to be covered. See the *dentally necessary orthodontic care* benefit description in the **What Is Covered** section for more information.

Dependent

is any *member* of a *subscriber's* family who meets all of the eligibility requirements of this *EOC*, who is enrolled hereunder, and for whom the prepayment required here has actually been received by *us*.

Effective date

is the date coverage begins for *you* and/or *your dependents* enrolled in *HealthKeepers*.

Emergency

is the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity; this includes severe pain that, without immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to result in:

- serious jeopardy to the mental or physical health of the individual;
- danger of serious impairment of the individual's body functions;
- serious dysfunction of any of the individual's bodily organs; or
- in the case of a pregnant woman, serious jeopardy to the health of the fetus.

If you are experiencing an emergency please call 911 or visit the nearest hospital for treatment.

Evidence of Coverage ("EOC")

is the agreement between *us* and the *subscriber*. It includes this *EOC*, your **Summary of Cost-Shares and Benefits**, *your* application, any supplemental application or change form, *your* identification card, and any endorsements or riders.

Exchange

a governmental agency or non-profit entity that makes *qualified health plans* such as this plan available to *qualified individuals*.

Experimental/Investigative

is any service or supply that is judged to be *experimental* or *investigative* at *HealthKeepers* sole discretion. Nothing in this exclusion shall prevent a *member* from appealing *HealthKeepers* decision that a service is *experimental/investigative*. Services which do not meet each of the following criteria will be excluded from coverage as *experimental/investigative*:

1) Any supply or *drug* used must have received final approval to market by the U.S. Food and Drug Administration ("FDA") for the particular indication or application in question. Moreover, quantities of any *drug* or medication used must be within recommended maximum daily dose or duration

established by the FDA or any of the standard reference compendia defined below. There are two exceptions which apply when a *drug* has received final approval to market by the FDA, but not for the particular indication or application in question.

2) This criterion will be satisfied if the use of the *drug* is recognized for treatment of the indication or application in any of the following resources:

    - the following three standard reference compendia defined below: 1) American Hospital Formulary Service -Drug Information 2) National Comprehensive Cancer Network's Drugs & Biologics Compendium 3) Elsevier Gold Standard's Clinical Pharmacology
    - in substantially accepted peer-reviewed medical literature. Peer-reviewed medical literature means a scientific study published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts. This study must appear in a journal that has been determined by the International Committee of Medical Journal Editors to have met the Uniform Requirements for Manuscripts submitted to biomedical journals. Peer-reviewed medical literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier.

3) In the case where the *drug* is being used for the treatment of a specific type of cancer, this criterion will be satisfied if the use of the *drug* is recognized as safe and effective for treatment of the specific type of cancer in any of the standard reference compendia.

4) Despite the above two exceptions, this criterion will not be satisfied if the FDA has determined that use of the *drug* is not recommended for the treatment of the specific indication for which it is prescribed.

1. There must be enough information in the peer-reviewed medical and scientific literature to let *us* judge the safety and efficacy.
2. The available scientific evidence must show a good effect on health outcomes outside a research setting.
3. The service or supply must be as safe and effective outside a research setting as current diagnostic or therapeutic options.

New technologies are evaluated against these criteria to determine if services should be included as a covered benefit or considered *experimental/investigative*.

Facility

is a *facility* including but not limited to, a *hospital*, freestanding ambulatory surgical *facility*, chemical dependency treatment *facility*, skilled nursing *facility*, home health care agency or mental health *facility*, as defined in this *EOC*. The *facility* must be licensed, registered or approved by the Joint Commission on Accreditation of Hospitals or meet specific rules set by *us*.

Formulary

is a listing of *prescription drugs* that are determined by *HealthKeepers* in its sole discretion to be designated as covered *drugs*. The list of approved *prescription drugs* developed by *HealthKeepers* in consultation with physicians and pharmacists has been reviewed for their quality and cost effectiveness. This *formulary* contains a limited number of *prescription drugs*, and may be different than the *formulary* for other *HealthKeepers* products. Generally, it includes select *generic drugs* with limited *brand prescription drugs* coverage. This list is subject to periodic review and modification by *HealthKeepers*. *We* may add or

delete *prescription drugs* from this *formulary* from time to time. A description of the *prescription drugs* that are listed on this *formulary* is available upon request and at www.anthem.com.

Generic Drugs

means a *prescription drug* that the PBM (Pharmacy Benefits Manager) has classified as *generic drugs* through use of an independent proprietary industry database. *generic drugs* have the same active ingredients, must meet the same FDA rules for safety, purity and potency, and must be given in the same form (tablet, capsule, cream) as the *brand name drug*.

Habilitative Services

are services that help *you* keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of *inpatient* and/or *outpatient* settings.

HealthKeepers Physician

is a duly licensed doctor of medicine or osteopathy who has contracted with *HealthKeepers* to provide medical services to *members*.

HealthKeepers Provider

is a medical group, *HealthKeepers physician*, *hospital*, skilled nursing *facility*, *pharmacy*, or any other duly licensed institution or health professional who has contracted with *HealthKeepers* or its designee to provide *covered services* to *members*. A list of *HealthKeepers providers* is made available to each *subscriber* prior to enrollment. A current list may be obtained from *HealthKeepers* upon request and may be seen by visiting *HealthKeepers* website page at www.anthem.com. The list shall be revised by *HealthKeepers* from time to time as *HealthKeepers* deems necessary.

HealthKeepers, we, us, our

refers to *HealthKeepers*, Inc.

High Dose

is a dose of chemotherapy or radiation so high that it predictably requires stem cell rescue.

Home Care Services

are services rendered in the home setting. Home care includes services such as skilled nursing *visits* and physical, speech, and occupational therapy for patients confined to their homes. This also means home infusion services; which is therapy including such services as the intravenous and parenteral administration of medication to patients as well as enteral and parenteral nutrition. Home infusion therapy does not require that the patient is confined to his/her home.

Hospice Care

a coordinated plan of home, *inpatient* and *outpatient* care that provides palliative, supportive medical, psychological, psychosocial, and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a physician. Care is available 24 hours a day, seven days a week. The hospice must meet the licensing requirements of the *state* or locality in which it operates.

Hospital

A *provider* licensed and operated as required by law, which has:

1. room, board, and nursing care;
2. a staff with one or more doctors on hand at all times;
3. 24 hour nursing service;
4. all the *facilities* on site are needed to diagnose, care, and treat an illness or injury; and
5. is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

The term *hospital* does not include a *provider,* or that part of a *provider*, used mainly for:
1. nursing care
2. rest care
3. convalescent care
4. care of the aged
5. *custodial care*
6. educational care
7. subacute care
8. treatment of alcohol abuse
9. treatment of drug abuse

Inpatient

means when *you* are a bed patient in a *hospital* where a room and board charge is made. It does not mean a *member* who is placed under observation for fewer than twenty-four (24) hours.

Inpatient Facilities

are settings where patients can spend the night, including *hospitals* and skilled nursing *facilities*.

Maintenance Medication

is a *drug you* take on a regular, recurring basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If *you* are not sure if the *prescription drug you* are taking is a *maintenance medication*, please call Customer Service at the number on the back of *your* Identification Card or check *our* website at www.anthem.com for more details.

Maximum Allowed Amount (MAA)

is the allowance as determined by *HealthKeepers* for a specified *covered service* or the *provider's* charge for that service, whichever is less.

Medical Director

is a duly licensed physician or his designee who has been designated by *HealthKeepers* to monitor the provision of *covered services* to *members*.

Medical Equipment (Durable)

is used for a medical purpose, can withstand repeated use, and is appropriate for use in *your* home for *activities of daily living* purposes.

Medically Necessary/Medical Necessity

to be considered *medically necessary*, a service must:

- be required to identify or treat an illness, injury, or pregnancy-related condition;
- be consistent with the symptoms or diagnosis and treatment of *your* condition;
- be in accordance with standards of generally accepted medical practice; and
- be the most suitable supply or level of service that can safely treat the condition and not be for the convenience of the patient, patient's family, or the *provider*.

Member

is any *subscriber* or enrolled *dependent*.

Mental Health and Substance Use Disorder Services

is any condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition.

Minimum Essential Coverage

is any of the following: Government sponsored programs Medicare, Medicaid, CHIP, TRICARE for Life, veteran's health care program); coverage under an eligible employer-sponsored plan; coverage under a health plan offered in the individual market within a *state*; coverage under a grandfathered health plan, and such other health benefits coverage, such as a *state* health benefits risk pool, or as the Secretary of HHS recognizes.

Multi-source Brand Name Drugs

are *brand-name drugs* that are available from more than one manufacturer and often but do not always have at least one *generic e*quivalent alternative available.

Non-Participating Pharmacy

is a *pharmacy* that does not have a *participating pharmacy* agreement in effect with or for the benefit of *HealthKeepers* at the time services are rendered. In most instances, *you* will be responsible for a larger portion of *your* pharmaceutical bill when *you* go to a *non-participating pharmacy*.

Out-of-Plan Benefits

are benefits for care received from a non-*HealthKeepers provider*.

Out-of-Pocket Limit

is a specified dollar amount of expense incurred for *covered services* in a calendar year as listed in the **Schedule of Cost Shares and Benefits**. Such expense does not include charges in excess of the *maximum allowed amount* or any non-covered services. Refer to the **Schedule of Cost Shares and Benefits** for other services that may not be included in *the out-of-pocket limit*. When the *out-of-pocket limit* is reached, no additional *cost sharing* is required unless otherwise specified in this *EOC.*

Outpatient

refers to a person receiving care in a setting such as a *hospital outpatient* department, emergency room, professional *provider's* office, or *your* home.

Participating Pharmacy

is a *pharmacy* that has a *participating pharmacy* agreement in effect with or for the benefit of *HealthKeepers* at the time services are rendered. *Participating pharmacies* may be based on a restricted network, and may be different than the network of *participating pharmacies* for other *HealthKeepers* products. To find a *participating pharmacy* near *you*, call **Member Services** at the telephone number on *your* ID card.

Pharmacy

is a place licensed by *state* law where *you* can get *prescription drugs* and other medicines from a licensed pharmacist when *you* have a prescription from *your* doctor.

Pharmacy and Therapeutics (P&T) Process

is a process to make clinically based recommendations that will help *you* access quality, low cost medicines within *your EOC*. The process includes health care professionals such as nurses, pharmacists, and doctors. The committees of the Anthem National Pharmacy and Therapeutics Process meet regularly to talk about and find the clinical and financial value of medicines for our *members*. This process first evaluates the clinical evidence of each product under review. The clinical review is then combined with an in-depth review of the market dynamics, *member* impact and financial value to make choices for the *formulary*. *Our* programs may include, but are not limited to, *drug* utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and *drug* profiling initiatives.

Plan Year

is a consecutive 12 month period during which a health plan provides coverage for the health benefits. A *plan year* may be a calendar year or otherwise.

Post-Service Claims

are all claims other than *pre-service claims* and *urgent care claims*. *Post-service claims* include claims filed after services are rendered and claims that do not require authorization in advance of the service, even where *you* request authorization in advance.

Premium

are the periodic charges due which the *subscriber* must pay *us* to maintain coverage.

Pre-Service Claims

are claims for a service where the terms of the *EOC* require the *member* to obtain approval of the benefit, in whole or in part, in advance of receipt of the service. If *you* call to receive authorization for a service when authorization in advance is not required, that claim will be considered a *post-service claim*.

Prescription Drug (Drug)

is a medicine that is made to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, “Caution: Federal law prohibits dispensing without a prescription.” This includes insulin, diabetic supplies, and syringes.

Primary Care Physician (PCP)

is the general or family practitioner, internist or pediatrician you choose to provide, arrange and/or authorize any health care services *you* and *your* family members may need.

Provider

is a professional or *facility* licensed by law that gives health care services within the scope of that license and is approved by *us*. This includes any *provider* that state law says *we* must cover when they give *you* services that state law says *we* must cover. *Providers* that deliver *covered services* are described throughout this *EOC*. If *you* have a question about a *provider* not described in this *EOC* please call the number on the back of *your* identification card.

Qualified Health Plan or QHP

is a health plan that has in effect a certification issued or recognized by each *exchange* through which such health plan is offered.

Qualified Health Plan Issuer or QHP Issuer

Is a health plan insurance issuer that offers a *QHP* in accordance with the certification from an *exchange*.

Qualified Individual

is, with respect to an *exchange*, an individual who has been determined eligible to enroll through the *exchange* in a *QHP* in the individual market.

Referral

is authorization from *your PCP* to receive services from another *provider*, however *your* coverage does not require that *you* obtain a *referra*l from *your PCP* to receive care from other *HealthKeepers providers*.

Retail Health Clinic

is a clinic that provides limited basic medical care services to *members* on a “walk-in” basis. These clinics normally operate in major pharmacies or retail stores. Medical services are typically provided by physician’s assistants and nurse practitioners.

Self-Administered Drugs

drugs that are administered which do not require a medical professional to administer.

Service Area

is all of Virginia, excluding the City of Fairfax, the Town of Vienna and the area east of State Route 123.

Single-source Brand Name Drugs

are *brand name drugs* that are available from only one manufacturer and are patent protected. No *generic* equivalent is available.

Specialty Care Physician (Specialist or SCP)

A *specialist* is a doctor who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-physician *specialist* is a *provider* who has added training in a specific area of health care.

Specialty Drugs

are *drugs* that are high-cost, injectable, infused, oral or inhaled *drugs* that generally require close supervision and monitoring of their effect on the patient’s *drug* therapy by a medical professional. These

drugs often require special handling, such as temperature controlled packaging and overnight delivery, and are often unavailable at retail *pharmacies*.

Stabilize (Stabilization)

means to provide treatment that assures that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a *facility*, or with respect to a pregnant woman, that the woman has delivered, including the placenta.

State

is each of the 50 States and the District of Columbia.

Stay

is the period from the admission to the date of discharge from a *facility*, including *hospitals*, hospices, and skilled nursing *facilities*. All *facility* stays, less than 90 days apart are considered the same stay.

Subscriber

is the *member* and his/her *dependents* (if any) who meet the eligibility requirements of this e*vidence of coverage* and enrolls in *HealthKeepers*.

Tax Dependent

has the same meaning as the term *dependent* under the Internal Revenue Code.

Tax Filer

is an individual, or a married couple, who indicates that he, she or they expect.

1. To file an income tax return for the *benefit year*;
2. If married, per IRS guidelines, to file a joint tax return for the *benefit year*;
3. That no other taxpayer will be able to claim him, her or them as a *tax dependent* for the *benefit year*; and
4. That he, she, or they expects to claim a personal exemption deduction on his or her tax return for one or more applicants, who may or may not include himself or herself and his or her spouse.

Telemedicine services

means the use of electronic technology or media, including interactive audio or video for the purpose of diagnosing or treating a patient or consulting with other health care *providers* regarding a patient's diagnosis or treatment. *Telemedicine services* does not include an audio-only telephone conversations, electronic mail message, facsimile transmission or online questionnaire.

Tier One Drugs

includes low cost and preferred *drugs* that may be *generic drugs*, *single-source brand name drugs*, or *multi-source brand name drugs*.

Tier Two Drugs

includes preferred *drugs* considered *generic drugs*, *single-source brand name drugs*, or *multi-source brand name drugs*.

Tier Three Drugs

includes *drugs* considered *generic drugs*, *single-source brand name drugs*, or *multi-source brand name drugs*.

Tier Four Drugs

contains high cost *drugs*. This includes *drugs* considered *generic drugs*, *single-source brand name drugs*, and *multi-source brand name drugs*.

Tier 1 and Tier 2 Hospitals

We have designated certain *hospitals* as participating in Tier 1 or Tier 2. *Tier 1 hospitals* have lower costs to the *member*. *Tier 2 hospitals* are more costly. This tier ranking is based solely on cost of services (unless no *hospitals* in the county met the financial criteria used to designate Tier 1). While these *hospitals* are contracted with *us*, *we* make no representation on the relative quality of the services. When a *member* goes to an out-of-network *hospital*, there is no agreement on the cost of the service and the *member* is responsible for the amounts above the *maximum allowed amount* and for separate out-of-network *cost-shares*.

Urgent Care Claims

are claims where care and services are actively ongoing and to which the application of time periods for making claim or appeal decisions could seriously jeopardize the patient's life, health or ability to regain maximum function, or in the opinion of the patient's physician, would subject the patient to severe pain. Notwithstanding any provision of this *EOC*, services for an *emergency* do not require *PCP referrals* or any type of *HealthKeepers* advance approval.

Urgent Care Situations

are medical conditions that require immediate attention, but are not as severe as an *emergency*. *Urgent care situations* are usually marked by the rapid onset of persistent or unusual discomfort associated with an illness or injury.

Visit

is a period during which a *member* meets with a *provider* to receive *covered services*.

You, Your

any *member*.