# Evidence of Coverage

## Anthem HealthKeepers Silver X 5000 S06


**This Plan is a Health Maintenance Organization (HMO) product.**
**HealthKeepers, Inc. (HealthKeepers)**
**P.O. Box 26623**
**Richmond, VA 23261-6623**
1-800-901-0020

**www.anthem.com**

**THIS CONTRACT MAY NOT APPLY WHEN YOU HAVE A CLAIM! PLEASE READ! This contract was issued based on the information entered in Your application, a copy of which is attached to the policy. If You know of any misstatement in Your application, You should advise HealthKeepers immediately regarding the incorrect or omitted information; otherwise, Your contract may not be valid.**

### Guaranteed Renewable

Coverage under this Evidence of Coverage is guaranteed renewable, except as permitted to be terminated, cancelled, rescinded, or not renewed under applicable state and federal law , provided the Member is a Qualified Individual as determined by the Exchange .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 Evidence of Coverage 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 fact on the application or under the terms of this Evidence of Coverage.
3. This Evidence of Coverage has not been terminated by the Exchange.

We may non-renew or discontinue your coverage if:
1. You have failed to pay premiums or contributions in accordance with the terms of this Certificate of Coverage or We have not received timely premium payments;
2. We are ceasing to offer coverage in the individual market;
3. You no longer reside, live, or work in the Service Area.

## RIGHT TO EXAMINE

**As a new Subscriber, if You are not satisfied with this Evidence of Coverage, return it to Us within 10 days after You receive it. The premium You paid will be promptly refunded. If You return this Evidence of Coverage to Us within 10 days, it will be as if no Evidence of Coverage was ever issued.**

# Welcome to HealthKeepers!

The benefits, terms and conditions of this Evidence of Coverage are applicable to individuals who are determined by the Exchange to be Qualified Individuals for purposes of enrollment in a Qualified Health Plan (QHP).

We are pleased that You have become a Member of Our health Plan, where it's Our mission to improve the health of the people We serve. We've designed this Evidence of Coverage to give a clear description of Your benefits, as well as, Our rules and procedures.

This Evidence of Coverage explains many of the rights and duties between You and Us. It also describes how to get healthcare, what services are covered, and what part of the costs You will need to pay. Many parts of this Evidence of Coverage are related. Therefore, reading just one or two sections may not give You a full understanding of Your coverage. You should read the whole Evidence of Coverage to know the terms of Your coverage.

This Evidence of Coverage, the application, and any amendments or riders attached shall constitute the entire Evidence of Coverage under which Covered Services and supplies are provided by Us.

This Evidence of Coverage is issued in consideration of Your completed application and Your first premium payment.

Many words used in the Evidence of Coverage have special meanings (e.g., Covered Services, and Medical Necessity). These words are capitalized and are defined in the "Definitions" section. See these definitions for the best understanding of what is being stated. Throughout this Evidence of Coverage, You will also see references to "We," "Us," "Our," "You," and "Your." The words "We," "Us," and "Our" mean HealthKeepers. The words "You" and "Your" mean the Member, Subscriber and each covered Dependent.

If You have any questions about Your Plan, please be sure to call Member Service at the number on the back of Your Identification Card. Also, be sure to check Our website, www.anthem.com for details on how to find a Provider, get answers to questions, and access valuable health and wellness tips. Thank you again for enrolling in the Plan!

**HealthKeepers**

Jeff Ricketts
President

## How to obtain Language Assistance

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 help You. Translation of written materials about Your benefits can also be asked for by contacting Member Services. Teletypewriter/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.

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamado 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.)

## Identity Protection Services

Identity protection services are available with our HealthKeepers health Plans. To learn more about these services, please visit https://anthemcares.allclearid.com/.

## Contact Us

Member Services is available to explain policies and procedures, and answer questions regarding the availability of benefits.

For information and assistance, a Member may call or write HealthKeepers.

The telephone number for Member Services is printed on the Member's Identification Card. The address is: 2015 Staples Mill Road Richmond, VA 23230

**Visit Us on-line**
www.anthem.com

**Home Office Address**
2015 Staples Mill Road
Richmond, VA 23230

**Hours of operation**
Monday - Friday
8:00 a.m. to 5:00 p.m. Eastern Time

## Conformity with Law

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.

## Acknowledgement of Understanding

Subscriber hereby expressly acknowledges their understanding that this Evidence of Coverage constitutes a contract solely between Subscriber and HealthKeepers, 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 to use the Blue Cross and/or Blue Shield Service Mark(s) in a portion of the Commonwealth of Virginia, and that HealthKeepers is not contracting as the agent of the Association. Subscriber further acknowledges and agrees that it has not entered into this Evidence of Coverage based upon representations by any person other than HealthKeepers and that no person, entity, or organization other than HealthKeepers shall be held accountable or liable to Subscriber for any of HealthKeepers obligations to Subscriber created under this Evidence of Coverage. This paragraph shall not create any additional obligations whatsoever on the part of HealthKeepers other than those obligations created under other provisions of this agreement.

## Delivery of Documents

We will provide an Identification Card and Evidence of Coverage for each Subscriber.

## Federal Patient Protection and Affordable Care Act Notices

### Choice of Primary Care Physician

We allow the designation of a Primary Care Physician (PCP). You have the right to designate any PCP who participates in Our network and who is available to accept You or Your family members. For information on how to select a PCP, and for a list of PCPs, contact the telephone number on the back of Your Identification Card or refer to Our website, www.anthem.com. For children, You may designate a pediatrician as the PCP.

### Access to Obstetrical and Gynecological (OB/GYN) Care

You do not need prior authorization from Us or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a healthcare professional in Our network who specializes in obstetrics or gynecology. The healthcare professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, or procedures for making referrals. For a list of participating healthcare professionals who specialize in obstetrics or gynecology, contact the telephone number on the back of Your Identification Card or refer to Our website,

www.anthem.com.

# TABLE OF CONTENTS

## Anthem HealthKeepers Silver X 5000 S06

# SCHEDULE OF COST SHARE AND 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.

Services will only be Covered Services if rendered by in-network Providers unless:

- The services are for Emergency Care, ambulance services related to an Emergency for transportation to a Hospital, or Urgent Care services received at an Urgent Care Center; or
- The services are approved in advance by HealthKeepers.

**IMPORTANT: You are responsible for confirming that the Provider You are seeing or have been referred to see is an in-network Provider for this Evidence of Coverage. It is important to understand that HealthKeepers has many contracting Providers who may not be part of the network of Providers that applies to this Evidence of Coverage. The name of the network for this Evidence of Coverage is located on Your Identification Card.**

**We can help You find an in-network Provider specific to Your Evidence of Coverage by calling the number on the back of Your Identification Card.**

### What will I pay?

Reimbursement for Covered Services is based on the Maximum Allowed Amount, which is the most Your Evidence of Coverage will allow for a Covered Service.

The Deductible applies to all Covered Services with a Copayment and/or Coinsurance, including 0% Coinsurance, except for:

- In-network Preventive Care Services required by law
- Pediatric Vision Services
- Services, listed in the chart below, that specifically indicate that the Deductible does not apply

For a detailed explanation of how Your Deductibles and Out-of-Pocket Limits are calculated, see the "How Your Claims Are Paid" section. When You receive Covered Services from an out-of-network Provider, You may also be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges.

### Plan Features

| Deductible | In-Network<br>Member Pays | Out-of-Network<br>Member Pays |
|---|---|---|
| **Individual** | $50 | Not Covered |
| **Family** | $100 | Not Covered |
| The individual Deductible amount applies separately to each covered Member, per Calendar Year. If You, the Subscriber, are the only person covered by this Evidence of Coverage, then only the individual Deductible amount(s) apply.<br>If You have family Members covered under this Evidence of Coverage, 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<br>Member Pays | Out-of-Network<br>Member Pays |
|---|---|---|
| **Coinsurance Percentage**<br>Unless specified otherwise below | 5% Coinsurance | Not Covered |

| Out-of-Pocket Limit | In-Network<br>Member Pays | Out-of-Network<br>Member Pays |
|---|---|---|
| **Individual** | $1,250 | Not Covered |
| **Family** | $2,500 | Not Covered |

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 Evidence of Coverage, then only the individual Out-of-Pocket amount(s) apply.

If You have family members covered under this Evidence of Coverage, 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.

## Medical Services

| Medical Services | In-Network<br>Member Pays | Out-of-Network<br>Member Pays |
|---|---|---|
| **Ambulance Services**<br>**Emergency** | $0 Copayment<br>5% Coinsurance | $0 Copayment<br>5% Coinsurance |
| **Nonemergency**<br>If Preauthorized by Us, out-of-network nonemergency ambulance services are subject to the same Cost Share as in-network services up to $50,000 per occurrence. In addition to Your Cost Share, You will be responsible for amounts over the Maximum Allowed Amount except for air ambulance services. | $0 Copayment<br>5% Coinsurance | Not Covered |
| **Autism Services**<br>Including Applied Behavioral Analysis Services | Cost Share determined by place of service and the Covered Service received | |
| **Dental Services**<br>When provided for Inpatient or Outpatient in a Facility, accidental injury, preparation for medical services or for certain Members requiring general anesthesia | Cost Share determined by place of service and the Covered Service received | |
| **Diabetes Services**<br>Includes Outpatient self-management training, management programs, supplies, equipment and education | Cost Share determined by place of service and the Covered Service received | |
| **Diagnostic Services; Outpatient**<br>**Diagnostic Laboratory and Pathology Services** | | |
| **Tier 1 Hospital** | $0 Copayment<br>5% Coinsurance | Not Covered |

| Medical Services | In-Network<br>Member Pays | Out-of-Network<br>Member Pays |
|---|---|---|
| **Tier 2 Hospital** | $0 Copayment<br>35% Coinsurance | Not Covered |
| **Freestanding Facility or Doctor's Office** | $0 Copayment<br>5% Coinsurance | Not Covered |
| **Diagnostic Imaging Services and Electronic Diagnostic Tests** | | |
| **Tier 1 Hospital** | $0 Copayment<br>5% Coinsurance | Not Covered |
| **Tier 2 Hospital** | $0 Copayment<br>35% Coinsurance | Not Covered |
| **Freestanding Facility or Doctor's Office** | $0 Copayment<br>5% Coinsurance | Not Covered |
| **Advanced Imaging Services** | | |
| **Tier 1 Hospital** | $0 Copayment<br>50% Coinsurance | Not Covered |
| **Tier 2 Hospital** | $0 Copayment<br>50% Coinsurance | Not Covered |
| **Freestanding Facility, Doctor's Office or Urgent Care Center** | $0 Copayment<br>50% Coinsurance | Not Covered |
| **Doctor (Physician) Visits** | | |
| **Office Visits with:**<br>• Primary Care Physician (PCP)<br>• Retail Health Clinic, includes all Covered Services received at a Retail Health Clinic | Deductible does not apply; $5 Copayment<br>0% Coinsurance | Not Covered |
| **Virtual Visits with PCP** | Deductible does not apply; $5 Copayment<br>0% Coinsurance | Not Covered |

| Medical Services | In-Network<br>Member Pays | Out-of-Network<br>Member Pays |
|---|---|---|
| **Virtual Visits with PCP from Our Online Provider, LiveHealth Online** (whether accessed directly or through Our mobile app, website, or HealthKeepers-enabled devices) | Deductible does not apply; $0 Copayment<br>0% Coinsurance | Not Covered |
| **Specialty Care Physician (SCP)** (including in-person and/or Virtual Visits) | $0 Copayment<br>5% Coinsurance | Not Covered |
| **Medical Chats and Virtual Visits** (including primary care) from Our online Provider K Health, through its affiliated Provider groups, in Our mobile app | Deductible does not apply; $0 Copayment<br>0% Coinsurance | Not Covered |
| **Other Office Services**<br>Includes allergy services | $0 Copayment<br>5% Coinsurance | Not Covered |
| **Emergency Room Visits**<br>Additional Cost Share determined based on service received | $0 Copayment<br>40% Coinsurance | $0 Copayment<br>40% Coinsurance |
| **Home Care Services**<br>Limited to a maximum of 100 Visits per Member, per Calendar Year<br>The limit does not apply to home infusion therapy or home dialysis<br>Private Duty Nursing care provided in the home setting is limited to a maximum of 16 hours per Member, per Calendar Year | $0 Copayment<br>5% Coinsurance | Not Covered |
| **Hospice Care** | $0 Copayment<br>5% Coinsurance | Not Covered |
| **Hospital Services** | | |
| **Inpatient or Outpatient Facility** | | |
| **Tier 1 Hospital** | $0 Copayment<br>5% Coinsurance | Not Covered |
| **Tier 2 Hospital** | $0 Copayment<br>35% Coinsurance | Not Covered |

| Medical Services | In-Network<br>Member Pays | Out-of-Network<br>Member Pays |
|---|---|---|
| **Freestanding Facility/ Ambulatory Surgical Center** | $0 Copayment<br>5% Coinsurance | Not Covered |
| **Professional Surgery Services** | $0 Copayment<br>5% Coinsurance | Not Covered |
| **Other Doctor & Professional Services**<br>Including anesthesiologist | $0 Copayment<br>5% Coinsurance | Not Covered |
| **Lymphedema** | Cost Share determined by place of service and the Covered Service received | |
| **Medical Supplies, Durable Medical Equipment, Orthotics, Prosthetics and Appliances** | $0 Copayment<br>5% Coinsurance | Not Covered |
| **Wigs**<br>Limited to one wig per Member, per Calendar Year after cancer treatment | | |
| **Prosthetics for limb replacement**<br>"Limb" means an arm, a hand, a leg, a foot, or any portion of an arm, a hand, a leg, or a foot | $0 Copayment<br>5% Coinsurance | Not Covered |
| **Mental Health Care and Substance Use Services** | | |
| **Inpatient Facility** | | |
| **Tier 1 Hospital** | $0 Copayment<br>5% Coinsurance | Not Covered |
| **Tier 2 Hospital** | $0 Copayment<br>35% Coinsurance | Not Covered |
| **Freestanding Facility Doctor & Professional Services** | $0 Copayment<br>5% Coinsurance | Not Covered |

| Medical Services | In-Network<br>Member Pays | Out-of-Network<br>Member Pays |
|---|---|---|
| **Outpatient Facility** | | |
| **Tier 1 Hospital** | $0 Copayment<br>5% Coinsurance | Not Covered |
| **Tier 2 Hospital** | $0 Copayment<br>5% Coinsurance | Not Covered |
| **Freestanding Facility** | $0 Copayment<br>5% Coinsurance | Not Covered |
| **Office Visits** | $0 Copayment<br>5% Coinsurance | Not Covered |
| **Physical Medicine and Rehabilitation**<br>**Inpatient or Outpatient Facility** | | |
| **Tier 1 Hospital** | $0 Copayment<br>5% Coinsurance | Not Covered |
| **Tier 2 Hospital** | $0 Copayment<br>35% Coinsurance | Not Covered |
| **Freestanding Facility/ Ambulatory Surgical Center** | $0 Copayment<br>5% Coinsurance | Not Covered |
| **Professional Surgery Services** | $0 Copayment<br>5% Coinsurance | Not Covered |
| **Other Doctor & Professional Services**<br>Including anesthesiologist | $0 Copayment<br>5% Coinsurance | Not Covered |
| **Inpatient and Outpatient Professional Services**<br>Limited to a maximum of 100 days, combined with Skilled Nursing Facility, per Member, per stay<br>**Note:** For Outpatient therapy limits, see the “Therapy Services – Outpatient” section | $0 Copayment<br>5% Coinsurance | Not Covered |

| Medical Services | In-Network<br>Member Pays | Out-of-Network<br>Member Pays |
|---|---|---|
| **Preventive Care Services** | Deductible does not apply;<br>$0 Copayment<br>0% Coinsurance | Not Covered |
| **Skilled Nursing Facility**<br>Limited to a maximum of 100 days per Stay | | |
| **Inpatient** | | |
| **Tier 1 Hospital** | $0 Copayment<br>5% Coinsurance | Not Covered |
| **Tier 2 Hospital** | $0 Copayment<br>35% Coinsurance | Not Covered |
| **Freestanding Facility** | $0 Copayment<br>5% Coinsurance | Not Covered |
| **Therapy Services – Outpatient**<br>Includes coverage for Chemotherapy, Radiation, Respiratory, Cardiac Rehabilitation, and Early Intervention Services for Dependent children from birth to age three. | | |
| **Tier 1 Hospital** | $0 Copayment<br>5% Coinsurance | Not Covered |
| **Tier 2 Hospital** | $0 Copayment<br>35% Coinsurance | Not Covered |
| **Freestanding Facility or Doctor's Office** | $0 Copayment<br>5% Coinsurance | Not Covered |

| Medical Services | In-Network<br>Member Pays | Out-of-Network<br>Member Pays |
|---|---|---|
| **Occupational Therapy**<br>**Freestanding Facility or Doctor's Office**<br>Combined to the same benefit limit as Physical Therapy. The below limits do not apply to Mental Health and Substance Use Disorder conditions.<br>Outpatient Rehabilitative Services limited to 30 Visits, per Member, per Calendar Year<br>Outpatient Habilitative Services limited to 30 Visits, per Member, per Calendar Year | $0 Copayment<br>5% Coinsurance | Not Covered |
| **Physical Therapy**<br>**Freestanding Facility or Doctor's Office**<br>Combined to the same benefit limit as Occupational Therapy. The below limits do not apply to Mental Health and Substance Use Disorder conditions.<br>Outpatient Rehabilitative Services limited to 30 Visits, per Member, per Calendar Year<br>Outpatient Habilitative Services limited to 30 Visits, per Member, per Calendar Year | $0 Copayment<br>5% Coinsurance | Not Covered |

| Medical Services | In-Network<br>Member Pays | Out-of-Network<br>Member Pays |
|---|---|---|
| **Speech Therapy**<br>**Freestanding Facility or Doctor's Office**<br>Outpatient Rehabilitative Services limited to 30 Visits per Member, per Calendar Year<br>Outpatient Habilitative Services limited to 30 Visits per Member, per Calendar Year<br>The limits do not apply to Mental Health and Substance Use Disorder conditions<br>**Note:** The limits for physical, occupational, and speech therapy will not apply if You get that care as part of the Hospice or early childhood intervention benefit, nor for the treatment of autism spectrum disorder<br>**Note:** When You get physical, occupational, speech therapy, or cardiac rehabilitation in the home, the home care Visit limit will apply instead of the Outpatient therapy services limits listed above | $0 Copayment<br>5% Coinsurance | Not Covered |
| **Spinal Manipulation and Manual Medical Therapy Services**<br>**Outpatient Rehabilitative Services**<br>Limited to 30 Visits per Member, per Calendar Year<br>**Outpatient Habilitative Services**<br>Limited to 30 Visits per Member, per Calendar Year<br>**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 | $0 Copayment<br>5% Coinsurance | Not Covered |

| Medical Services | In-Network<br>Member Pays | Out-of-Network<br>Member Pays |
|---|---|---|
| **Transplant Human Organ & Bone Marrow/Stem Cell/Cord Blood**<br>**Transplant Transportation and Lodging**<br>Covered as approved by Us.<br>**Unrelated Donor Search**<br>Limited to a maximum of the 10 best matched donors per transplant, identified by an authorized registry. | Cost Share determined by place of service and the Covered Service received | |
| **Urgent Care Center**<br>**Urgent Care Center Visit**<br><br><br><br>**Other Urgent Care Center Services**<br><br>Additional Cost Share determined based on service received | Deductible does not apply; $25 Copayment per Urgent Care visit<br>0% Coinsurance<br><br>$0 Copayment<br>5% Coinsurance | Deductible does not apply; $25 Copayment per Urgent Care visit<br>0% Coinsurance<br><br>$0 Copayment<br>5% Coinsurance |

## Prescription Drugs

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

| **Retail Pharmacy Prescription Drugs**<br>(30-day supply per Prescription) | **In-Network**<br>**Member Pays** | **Out-of-Network**<br>**Member Pays** |
|---|---|---|
| **Tier 1** | Deductible does not apply; $5.00 Copayment<br>0% Coinsurance | Not Covered |
| **Tier 2** | Deductible does not apply; $25.00 Copayment<br>0% Coinsurance | Not Covered |
| **Tier 3** | $0 Copayment<br>50% Coinsurance | Not Covered |
| **Tier 4** | $0 Copayment<br>50% Coinsurance | Not Covered |
| Coverage is limited to those drugs listed on Our Prescription Drug List (formulary). | | |
| Specialty Drugs must be purchased from the Pharmacy Benefit Manager's Specialty Pharmacy. | | |
| For FDA-approved, self-administered Hormonal Contraceptives, up to a 12-month supply is covered when dispensed or furnished at one time by a Provider or pharmacist, or at a location licensed or otherwise authorized to dispense drugs or supplies. | | |
| The per-Member Cost Share for a covered Prescription Drug that contains insulin and is used to treat diabetes will not exceed a total of $50 per 30-day supply when obtained in-network. The Deductible does not apply. | | |

| **Home Delivery Prescription Drugs**<br>(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**<br>**Member Pays** | **Out-of-Network**<br>**Member Pays** |
|---|---|---|
| **Tier 1** | Deductible does not apply; $15.00 Copayment<br>0% Coinsurance | Not Covered |
| **Tier 2** | Deductible does not apply; $75.00 Copayment<br>0% Coinsurance | Not Covered |
| **Tier 3** | $0 Copayment<br>50% Coinsurance | Not Covered |

| **Home Delivery Prescription Drugs**<br>(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 4** | $0 Copayment<br>50% Coinsurance | Not Covered |
| Coverage is limited to those drugs listed on Our Prescription Drug List (formulary). | | |
| Specialty Drugs must be purchased from the Pharmacy Benefit Manager's Specialty Pharmacy and are limited to a 30-day supply. | | |
| For FDA-approved, self-administered Hormonal Contraceptives, up to a 12-month supply is covered when dispensed or furnished at one time by a Provider or pharmacist, or at a location licensed or otherwise authorized to dispense drugs or supplies. | | |
| The per-Member Cost Share for a covered Prescription Drug that contains insulin and is used to treat diabetes will not exceed a total of $150 per 90-day supply when obtained in-network. The Deductible does not apply. | | |

## Pediatric Dental Services

The following pediatric dental services are covered for Members until the end of the month, in which they turn 19.

Covered Dental Services, unless otherwise stated below, are subject to the same Calendar Year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Cost Share and Benefits.

Please see Pediatric Dental Care in the “What is Covered” section for more information on pediatric dental services.

| Pediatric Dental Care | In-Network<br>Member Pays | Out-of-Network<br>Member Pays |
|---|---|---|
| **Diagnostic and Preventive Services** | 0% Coinsurance | Not Covered |
| **Basic Restorative Services** | 40% Coinsurance | Not Covered |
| **Oral Surgery Services** | 50% Coinsurance | Not Covered |
| **Endodontic Services** | 50% Coinsurance | Not Covered |
| **Periodontal Services** | 50% Coinsurance | Not Covered |
| **Major Restorative Services** | 50% Coinsurance | Not Covered |
| **Prosthodontic Services** | 50% Coinsurance | Not Covered |
| **Dentally Necessary Orthodontic Care Services** | 50% Coinsurance | Not Covered |

## Pediatric Vision Services

The following vision care services are covered for Members until the end of the month in which they turn 19.

Please see Pediatric Vision Care in the "What Is Covered" section for more information on pediatric vision services.

Covered pediatric vision services are **not** subject to the Calendar Year Deductible.

| Covered Vision Services | In-Network<br>Member Pays | Out-of-Network<br>Member Pays |
|---|---|---|
| **Routine Eye Exam**<br>Covered once per Calendar Year per Member | $0 Copayment | Not Covered |
| **Standard Plastic Lenses**<br>One set of lenses covered per Calendar Year per Member. | | |
| **Single Vision** | $0 Copayment | Not Covered |
| **Bifocal** | $0 Copayment | Not Covered |
| **Trifocal** | $0 Copayment | Not Covered |
| **Progressive** | $0 Copayment | Not Covered |
| **Additional Lens Options**<br>Covered lenses include factory scratch coating, UV coating, standard polycarbonate and standard photochromic at no additional cost when received from in-network Providers. | | |
| **Frames (formulary)**<br>One frame covered per Calendar Year per Member. | $0 Copayment | Not Covered |
| **Contact Lenses (formulary)**<br>Elective or non-elective contact lenses are covered once per Calendar Year per Member. | | |
| **Elective**<br>(conventional and disposable) | $0 Copayment | Not Covered |
| **Non-Elective** | $0 Copayment | Not Covered |
| **Important Note:** Benefits for contact lenses are in lieu of Your eyeglass lens benefit. If You receive contact lenses, no benefit will be available for eyeglass lenses until the next Calendar Year. | | |
| **Low Vision**<br>Low vision benefits are only available when received from Blue View Vision Providers. | | |

| Covered Vision Services | In-Network<br>Member Pays | Out-of-Network<br>Member Pays |
|---|---|---|
| **Comprehensive Low Vision Exam**<br>Covered once per Calendar Year per Member | $0 Copayment | Not Covered |
| **Optical/non-optical aids and supplemental testing**<br>Limited to one occurrence of either optical/non-optical aids or supplemental testing per Calendar Year per Member. | $0 Copayment | Not Covered |

# HOW YOUR COVERAGE WORKS

The purpose of this section is to help You understand how to receive the highest level of benefits available under this Plan. It provides details about in-network Providers who have entered into an agreement with HealthKeepers and out-of-network Providers who have not. You will also find information about how to access a list of in-network Providers in Your Service Area and the importance of choosing a Primary Care Physician.

Your Plan is an HMO Plan. To get benefits for Covered Services, You must use in-network Providers, unless We have approved an Authorized Service or if Your care involves Emergency Care, ambulance services related to an Emergency for transportation to a Hospital, or Urgent Care services received at an Urgent Care Center.

In addition to Virginia's Balance Billing law, which became effective January 1, 2021, the federal "No Surprises Act" was signed into law as part of the Consolidated Appropriations Act of 2021. It includes many of the provisions already in effect under Virginia's Balance Billing law.

## In-Network Services

If Your care is rendered by a Primary Care Physician (PCP), Specialty Care Physician (SCP), or another in-network Provider, benefits will be paid at the in-network level. Regardless of Medical Necessity, no benefits will be paid for care that is not a Covered Service even if performed by a PCP, SCP, or another in-network Provider. All medical care must be under the direction of doctors. We have final authority to determine the Medical Necessity of the service.

We may inform You that it is not Medically Necessary for You to receive services or remain in a Hospital or other Facility. This decision is made upon review of Your condition and treatment. You have the right to file a grievance as outlined in the "If You Have a Complaint or an Appeal" section of this Evidence of Coverage.

- In-network Providers - include PCPs, SCPs, other professional Providers, Hospitals, and other Facility Providers who contract with Us to perform services for You. PCPs include general practitioners, internists, family practitioners, pediatricians, geriatricians or other in-network Providers as allowed by Us. The PCP is the doctor who may provide, coordinate, and arrange Your healthcare services. SCPs are in-network doctors who provide specialty medical services not normally provided by a PCP.

For services rendered by in-network Providers:

- You will not be required to file any claims for services You obtain directly from in-network Providers. In-network Providers will seek compensation for Covered Services rendered from Us and not from You except for approved Deductibles, Coinsurance, and/or Copayments. You may be billed by Your in-network Provider(s) for any non-Covered Services You receive or when You have not acted in accordance with this Evidence of Coverage.
- When required, prior approval of benefits is the responsibility of the in-network Provider. See the "Requesting Approval for Benefits" section.

If there is no in-network Provider who is qualified to perform the treatment You require, contact Us prior to receiving the service or treatment, and We may approve an out-of-network Provider for that service as an Authorized Service.

## Out-of-Network Services

Covered Services which are not obtained from a PCP, SCP or another in-network Provider, or that are not an Authorized Service will be considered an out-of-network service and not covered under Your Plan. The only exceptions are Emergency Care, ambulance services related to an Emergency for transportation to a Hospital, nonemergency surgical/ancillary services provided to an enrollee at an in-network facility by an out-of-network provider, or Urgent Care services received at an Urgent Care Center.

HealthKeepers has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking services from non-participating or out-of-network

Providers could be balance billed by the non-participating/out-of-network Provider for those services that are determined to be not payable as a result of these review processes. . The exception to this is outlined in “Balance Billing by Out-of-Network Providers” in the “How Your Claims Are Paid” section. 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.

## How to Find a Provider in the Network

There are several 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.
- Search for a Provider in Our mobile app, website, or HealthKeepers-enabled devices. Details on how to download the app can be found on Our website, www.anthem.com.
- Contact 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 Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with Us to help with Your needs.

You do not need a Referral to see a Specialty Care Physician. You can visit any in-network Specialist including a behavioral health Provider without a Referral from a Primary Care Physician.

## Primary Care Physician (PCP)

The Primary Care Physician (PCP) is a doctor who can provide initial care, basic medical services and can be responsible for ongoing patient care. PCPs are usually internal medicine doctors, family practice doctors, general practitioners, or pediatricians. As Your first point of contact, the PCP gives a wide range of healthcare services, including initial diagnosis and treatment, health supervision, management of chronic conditions, and preventive care.

**The First Thing To Do – Make an Appointment With Your PCP**

Your PCP's job is to help You stay healthy, not just treat You when You are sick. After You choose a PCP, make an appointment with Your PCP. During this appointment, get to know Your PCP and help Your PCP get to know You. At Your first appointment, talk to Your PCP about:

- Personal health history.
- Family health history.
- Lifestyle.
- Any health concerns You have.

It is important to note, if You have not established a relationship with Your PCP, they may not be able to effectively treat You. To see a doctor, call their office:

- Tell them You are a HealthKeepers Member,
- Have Your Member Identification 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 Identification Card with You.

## Connect with Us Using Our Mobile App

As soon as You enroll in this Plan, You should download Our mobile app. You can find details on how to

do this on Our website, www.anthem.com.

Our goal is to make it easy for You to find answers to Your questions. You can chat with Us live in the app, or contact Us on Our website, www.anthem.com, or through a HealthKeepers-enabled device.

## Dental Providers

You must select an in-network dentist to receive dental benefits. Please call Our Member Services department at 1-800-627-0004 for help in finding an in-network dentist or visit Our website at www.anthem.com. 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.

## Continuity of Care

If Your in-network Provider leaves Our Network for any reason other than termination for cause and You are in an active course of treatment, You may be able to continue seeing that Provider for a limited period of time and still receive in-network benefits. "Active course of treatment" for any course of Medically Necessary continuing care includes, but is not limited to:

1) An active course of treatment for an illness,
2) The second or third trimester of pregnancy and through the postpartum period for that delivery,
3) Members who are terminally ill as defined by the Social Security Act, or
4) An ongoing course of treatment for a health condition for which the doctor or healthcare Provider attests that discontinuing care by the current doctor or Provider would worsen Your condition or interfere with anticipated outcomes.

An "active course of treatment" includes treatments for Mental Health and Substance Use Disorders.

For Members who are terminally ill, coverage is extended for the remainder of the person's life for the direct care of the terminal illness. For Members who are in the second or third trimester of pregnancy, coverage is extended through the postpartum care for that delivery. In all other circumstances, You may be able to continue seeing that Provider for 90 days. If You wish to continue seeing the same Provider, You or Your doctor should contact Member Services for details.

In the absence of Prior Authorization for coverage at the in-network level, You may choose to receive services on an out-of-network basis.

## Identification Card

When You receive care, You must show Your Identification Card. Only a Member who has paid the Premiums under this Evidence of Coverage has the right to services or benefits under this Evidence of Coverage. If anyone receives services or benefits to which he/she is not entitled to under the terms of this Evidence of Coverage, he/she is responsible for the actual cost of the services or benefits.

## 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 Evidence of Coverage.

## 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;
- Laboratory 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 seven days a week. Please see the number on Your ID Card.

## Outside the Service Area

HealthKeepers does business only within a certain geographic area in the Commonwealth of Virginia. See the Inter-Plan/BlueCard® Program in the "How Your Claims Are Paid" section for an explanation of how Covered Services are administered when 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 may be responsible for payment of charges at the time of Your Visit. The exception to this is outlined in "Balance Billing by Out-of-Network Providers" in the "How Your Claims Are Paid" section; 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 You Must File a Claim" provision in the "How Your Claims Are Paid" section.

## 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 or as soon as possible after You begin receiving care. This applies to services received within or outside the Service Area.

## Hospital Admissions

All nonemergency Hospital admissions must be arranged by the Member's admitting HealthKeepers's doctor and approved in advance by Us, except for maternity admissions as specified under the Maternity benefit found in the "What Is Covered" section of this Evidence of Coverage. 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 two 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 doctor 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; and
- In the case of an Urgent Care claim, a description of the expedited review process applicable to such claims.

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. See the “Requesting Approval for Benefits” section for additional information.

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 nonemergency 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 (doctor, non-doctor, and Facility) related to the Hospital stay.

See the “Requesting Approval for Benefits” section for additional information.

## 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 healthcare 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 Plan. 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.

# REQUESTING APPROVAL FOR BENEFITS

Your Evidence of Coverage includes the process of Utilization Review to decide when services are Medically Necessary or Experimental/Investigative as those terms are defined in this Evidence of Coverage. Utilization Review aids in the delivery of cost-effective healthcare by reviewing the use of treatments and, when proper, level of care and/or the setting or place of service that they are performed. A service must be Medically Necessary to be a Covered Service. When level of care, setting or place of service is part of the review, services that can be safely given to You in a lower level of care or lower cost setting/place of care, will not be Medically Necessary if they are given in a higher level of care, or higher cost setting/place of care.

Certain services must be reviewed to determine Medical Necessity in order for You to get benefits. Utilization Review criteria will be based on many sources including medical policy and clinical guidelines. We may decide that a treatment that was asked for is not Medically Necessary if a Clinically Equivalent treatment is more cost effective, available and appropriate. “Clinically Equivalent” means treatments that for most Members, will give you similar results for a disease or condition.

If You have any questions about the utilization review process, the medical policies or clinical guidelines, You may call the Member Service phone number on the back of Your Identification Card.

**Coverage for or payment of the service or treatment reviewed is not guaranteed even if We decide Your services are Medically Necessary. 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, subject to the grace period;
3. The service or supply must be a Covered Service under Your Evidence of Coverage;
4. The service cannot be subject to an Exclusion under Your Evidence of Coverage; and
5. You must not have exceeded any applicable limits under Your Evidence of Coverage.

## Types of Reviews

- **Pre-service Review** – A review of a service, treatment or admission for a benefit coverage determination which is done before the service or treatment begins or admission date.
    - **Precertification** – A required Pre-service review for a benefit coverage determination for a service or treatment. Certain services require Precertification in order for You to get benefits. The benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity or is Experimental/Investigative as those terms are defined in this Evidence of Coverage.

      For admissions following Emergency Care, You, Your authorized representative or doctor must tell Us within 48 hours of the admission or as soon as possible. For labor / childbirth admissions, Precertification is not required for the first 48 hours for a vaginal delivery or 96 hours for a cesarean section. Admissions longer than 48/96 hours require Precertification.
- **Continued Stay/Concurrent Review** – A Utilization Review of a service, treatment or admission for a benefit coverage determination which must be done during an ongoing stay in a facility or course of treatment.

Both Pre-service and Continued Stay/Concurrent Reviews may be considered urgent when, in the view of the treating Provider or any doctor with knowledge of Your medical condition, without such care or treatment, Your life or health or Your ability to regain maximum function could be seriously threatened or You could be subjected to severe pain that cannot be adequately managed without such care or treatment.

Urgent reviews are conducted under a shorter timeframe than standard reviews.

- **Post-service Review** – A review of a service, treatment or admission for a benefit coverage that is conducted after the service or supply has been provided. Post-service reviews are performed when a service, treatment or admission did not need Precertification. Post-service reviews are done for a service, treatment or admission in which We have a related clinical coverage guideline and are typically initiated by Us.

## Who is Responsible for Precertification

Typically, In-network Providers know which services need Precertification and will get any Precertification 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 ("requesting Provider") will get in touch with Us to ask for a Precertification. However, You may request a Precertification, or 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. The table below outlines who is responsible for Precertification and under what circumstances.

| Provider Network Status | Responsibility to Get Precertification | Comments |
|---|---|---|
| In-network | Provider | The Provider must get Precertification when required. |
| Out-of-network | Member | The Member has no benefit coverage for an out-of-network Provider unless:<br>• The Member gets approval to use an out-of-network Provider before the service is given; or<br>• The Member requires an Emergency Care admission. (See note below.)<br>The Member may be financially responsible for charges/costs related to the service in whole or in part if the service is found not to be Medically Necessary. |
| BlueCard® Provider | Member<br>**(Except for Inpatient admissions)** | The Member has no benefit coverage for a BlueCard® Provider unless:<br>• The Member gets approval to use a BlueCard® Provider before the service is given; or<br>• The Member requires an Emergency Care admission (see note below).<br>If these are true, then:<br>• The Member must get Precertification when required (call Member Services). |

| | | |
|---|---|---|
| | | • The Member may be financially responsible for charges/costs related to the service in whole or in part if the service is found not to be Medically Necessary.<br>• **BlueCard® Providers must obtain Precertification for all Inpatient admissions.** |
| **NOTE: Precertification is not required to receive Emergency Care. For Emergency Care admissions, You, Your authorized representative or doctor must tell Us within 48 hours of the admission, or as soon as possible.** | | |

## How Decisions are Made

We will use Our clinical coverage guidelines, such as medical policy, clinical guidelines, and other applicable policies and procedures to help make Our Medical Necessity decisions. This includes decisions about Prescription Drugs, as detailed in the section "Prescription Drugs Administered by a Medical Provider". Medical policies and clinical guidelines reflect the standards of practice and medical interventions identified as proper medical practice. We reserve the right to review and update these clinical coverage guidelines from time to time.

You are entitled to ask for and get, free of charge, reasonable access to any records concerning Your request. To ask for this information, call the Precertification phone number on the back of Your Identification Card.

If You are not satisfied with Our decision under this section of Your benefits, please refer to the "If You Have a Complaint or an Appeal" section to see what rights may be available to You.

## 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 Evidence of Coverage was issued, other state-specific requirements may apply. You may call the phone number on the back of Your Identification Card for more details.

| **Type of Review** | **Timeframe Requirement for Decision and Notification** |
|---|---|
| Urgent pre-service review | 72 hours from the receipt of the request |
| Non-urgent pre-service review | Two business days from the receipt of the request |
| Urgent Continued Stay/Concurrent Review when no previous days authorized | 24 hours from receipt of request, We may request additional information within the first 24 hours and extend timeframe to 72 hours |
| Urgent concurrent/continued stay review when request is received more than 24 hours before the end of the previous authorization | 24 hours from the receipt of the request |

| Type of Review | Timeframe Requirement for Decision and Notification |
|---|---|
| Urgent concurrent/continued stay review when request is received less than 24 hours before the end of the previous authorization | 72 hours from the receipt of the request |
| Non-urgent concurrent/continued stay review | Two business days from the receipt of the request |
| Post-service review | Two business days from the receipt of the request |

If more information is needed to make Our decision, We will tell the requesting Provider of the specific information needed to finish the review. If We do not get the specific information We need by the required timeframe, We will make a decision based upon the information We have.

We will notify You and Your Provider of Our decision as required by State and federal law. Notice may be given by one or more of the following methods: verbal, written, and/or electronic.

## Important Information

HealthKeepers may, from time to time, waive, enhance, modify or discontinue certain medical management processes (including Utilization Review, case management, and disease management) and/or offer an alternative benefit if, in Our discretion, such change is in furtherance of the provision of cost effective, value based and/or quality services.

We may also 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 Your claim from medical review if certain conditions apply.

Just because HealthKeepers exempts 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 Member. HealthKeepers may stop or modify any such exemption, with or without advance notice.

You may find out whether a Provider is taking part in certain programs by checking Your on-line Provider Directory, on-line Pre-certification list, or contacting the Member Services number on the back of 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 Review guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to Plan's Members.

## Health Plan Individual Case Management

Our health plan case management programs (case management) helps coordinate services for Members with healthcare needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members 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 healthcare

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 You 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 Plan. We will make Our decisions case-by-case, if in Our discretion the alternate or extended benefit is in the best interest of the Member and HealthKeepers. 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. Nothing in this provision shall prevent You from appealing Our decision.

# WHAT IS COVERED

This section describes the Covered Services available under this Evidence of Coverage. Covered Services are subject to all the terms and conditions listed in this Evidence of Coverage, including, but not limited to, benefit maximums, Deductibles, Copayments, Coinsurance, exclusions and Medical Necessity requirements.

Please read the following sections of this Evidence of Coverage for more information about the Covered Services described in this section:

- “Schedule of Cost Share and Benefits” – for amounts You need to pay and benefit limits
- “Requesting Approval for Benefits” – for details on selecting Providers and services that require pre-certification
- “What is Not Covered (Exclusions)” – for details on services that are not covered

Benefits are listed alphabetically to make them easy to find. Please note that several sections may apply to your claims. For example, if You have Inpatient surgery, benefits for Your Hospital stay will be described under "Hospital Services”, “Inpatient Hospital Care" and benefits for Your doctor’s services will be described under "Inpatient Professional Services". As a result, You should read all sections that might apply to Your claims.

You should also know that many Covered Services can be received in several settings, including a doctor’s office, an Urgent Care Center, an Outpatient Facility, or an Inpatient Facility. Benefits will often vary depending on where You choose to get Covered Services, and this can result in a change in the amount You need to pay.

# Medical Services

## Ambulance Services (Air, Ground and Water)

Medically Necessary ambulance services are covered when:

- 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;
- And one or more of the following are met:
  You are taken:
  1. From Your home, scene of an 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 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 an injury by medical professionals during ambulance service, even if You are not taken to a Facility.

Out-of-network Providers may bill You for any charges that exceed the Plan's Maximum Allowed Amount, except for air ambulance services.

**Ground Ambulance**

Services are subject to Medical Necessity review by Us.

All scheduled ground ambulance services for nonemergency transports, not including acute Facility to acute Facility transport, must be preauthorized.

**Air and Water Ambulance**

Nonemergency 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 nonemergency Hospital to Hospital transports must be preauthorized.

Nonemergency ambulance services are subject to Medical Necessity review by Us. When using an air ambulance for nonemergency transportation, We reserve the right to select the air ambulance Provider. If You do not use the air ambulance Provider We select, the Out-of-Network Provider may bill You for any charges that exceed the Evidence of Coverage's Maximum Allowed Amount.

**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 types 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.

## Autism Services

Your health plan covers certain treatments associated with autism spectrum disorder (ASD) for Dependents. Coverage for ASD includes but is not limited to the following:

- diagnosis of autism spectrum disorder;
- treatment of autism spectrum disorder;
- pharmacy care;
- psychiatric care;
- psychological care; and
- therapeutic care.

Treatment for ASD includes Applied Behavior Analysis when provided or supervised by a board certified behavior analyst, licensed by the Board of Medicine, and billed by such behavior analyst, and the prescribing practitioner is independent of the Provider of the Applied Behavior Analysis.

Treatment for ASD also includes physical, occupational and speech therapy services. When associated with a diagnosis of ASD, these services will not apply to the benefit maximums for these services set forth in the "Therapy Services - Outpatient" section of the Schedule of Cost Share and Benefits.

## 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 Plan. 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 of Health and Human Services 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. The peer review requirement shall not be applicable to cancer clinical trials provided by i-iii below.
      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 (FDA);
3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Your Evidence of Coverage 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 Evidence of Coverage.

All requests for clinical trials services, including requests that are not part of Approved Clinical Trials will be reviewed according to our Clinical Coverage Guidelines, related policies and procedures.

## Dental Services

### Treatment of Accidental Injury

Benefits are available for medically necessary dental services resulting from an accidental dental injury. Treatment must begin within 12 months of the injury, or as soon after that as possible, to be a Covered Service under this Evidence of Coverage. 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 or the repair of dental appliances damaged as a result of an accidental injury to the jaw, mouth or face. An injury that results from chewing or biting is not considered an accidental injury under this Evidence of Coverage.

**Note:** We provide coverage only for functional repairs. Services of a cosmetic nature, or not deemed to be functional by Us, are not Covered Services.

### Preparing the Mouth for Medical Treatments

Your Evidence of Coverage includes coverage for dental services to prepare the mouth for medical services and treatments such as radiation therapy to treat cancer and prepare for transplants. Covered Services include:

- Evaluation
- Dental X-rays
- Extractions, including surgical extractions
- Anesthesia

### Hospitalization for Anesthesia and Dental Procedures

Your Evidence of Coverage includes coverage for general anesthesia and hospitalization services for children under the age of five, 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 doctor 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 "Requesting Approval for Benefits" section for important details on meeting Our admission review requirements.

## Diabetic Supplies, Equipment, and Education

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

- insulin pumps;
- home glucose monitors, lancets, glucose test strips, syringes and hypodermic needles 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 healthcare 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 doctor 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 Outpatient

Your Evidence of Coverage includes benefits for tests or procedures to find or check a condition when specific symptoms exist. Benefits are also available for the reading/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
- 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.
- Radiology (including mammograms) or nuclear medicine

**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
- QCT Bone Densitometry
- Diagnostic CT Colonography
- Single photon emission computed tomography (SPECT) scans

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

## Doctor (Physician) Visits

Covered Services include:

**Office Visits/Office Surgeries** for medical care (including second opinions) to examine, diagnose, and treat an illness or injury.

**Virtual Visits**

Covered Services include virtual Telemedicine/Telehealth visits that are appropriately provided through the internet via video, chat or voice. This includes visits with Providers who also provide services in person, as well as online-only Providers.

- **Medical Chats** Covered Services accessed through Our mobile app with a doctor via a text message or chat for limited medical care.
- **"Telemedicine/Telehealth"** means the delivery of healthcare or other health services using electronic communications and information technology, including: live (synchronous) secure videoconferencing; or secure instant messaging through Our mobile app, website, or HealthKeepers-enabled devices; interactive store and forward (asynchronous) technology; or remote patient monitoring technology. Covered Services are provided to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a patient's physical and/or mental health. In-person contact between a healthcare Provider and the patient is not required for these services, and the type of setting where these services are provided is not limited.

  "Remote patient monitoring" means the delivery of home health services using telecommunications technology to enhance the delivery of home healthcare, including monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and other condition-specific data; medication adherence monitoring; and interactive video

conferencing with or without digital image upload.

**Please Note:** Not all services can be delivered through virtual visits. Certain services require equipment and/or direct physical hands-on care that cannot be provided remotely. Also, please note that not all Providers offer virtual visits.

If You have any questions about this coverage, please contact Member Services at the number on the back of Your Identification Card.

**Home Visits** for medical care to examine, diagnose, and treat an illness or injury. Please note that doctor visits in the home are different than the "Home Care Services" benefit described later in this section.

**Retail Health Clinic Care** for limited basic healthcare services to Members on a "walk-in" basis. These clinics are normally found in major pharmacies or retail stores. Healthcare services are typically given by physician assistants or nurse practitioners. Services are limited to routine care and treatment of common illnesses for adults and children.

**Walk-In Doctor's Office** for services limited to routine care and treatment of common illnesses for adults and children. You do not have to be an existing patient or have an appointment to use a walk-in doctor's office.

**Allergy Services** for Medically Necessary allergy testing and treatment, including allergy serum and allergy shots.

**Specialist e-Consultations** are electronic communications between Your PCP, who is rendering care to You, and an in-network Specialist to help evaluate Your condition or diagnosis. The consultation will be at no cost to You. Your PCP may consider the information provided by the in-network Specialist in determining Your treatment. The consultation will be conducted using electronic information and communication technologies and the results may be documented in an electronic health record.

**Lymphedema** 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.

## Emergency Care Services

If You are experiencing an Emergency please call 911 or visit the nearest Hospital for treatment.

Benefits are available in a Hospital Emergency room, including independent freestanding Emergency Facility and professional services, as well as diagnostic X-ray, laboratory services, medical supplies, and advanced diagnostic imaging, such as MRIs and CAT scans, to treat and evaluate the onset of symptoms for an Emergency, which is defined below. Services that do not meet the definition of Emergency will not be covered as such. Coverage will be determined by the place of service and services received.

Visits to out-of-network Emergency rooms for Emergency Services (as defined in this Evidence of Coverage) and supplies are covered at in-network levels, and in-network Cost Share apply.

**Emergency (Emergency Medical Condition)**

"Emergency," or "Emergency Medical Condition", means, regardless of the final diagnosis rendered to You, a medical or behavioral health condition of sufficient severity, including, but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that not getting immediate medical care could result in: (a) placing the patient's health or the health of another person in serious danger or, for a pregnant woman, placing the woman's health or the health of her fetus in serious danger; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. Such conditions include, but are not limited to, chest pain, stroke, poisoning, serious breathing problems, unconsciousness, severe burns or cuts, uncontrolled bleeding, or seizures and such other acute conditions.

**Emergency Care** means a medical or behavioral health exam done in an independent freestanding Emergency Facility or the Emergency Department of a Hospital, and includes services routinely available in the Emergency Department to evaluate an Emergency Medical Condition. It includes any further

medical or behavioral health exams and treatment required to stabilize the patient.

**Stabilize**, with respect to an Emergency Medical Condition, means: To provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility. With respect to a pregnant woman, the term "stabilize" also means that the woman has delivered, including the placenta.

Medically Necessary services will be covered whether You get care from an in-network or out-of-network Provider. Emergency Care You get from an out-of-network Provider will be covered as an in-network service, and as outlined in "Balance Billing by Out-of-Network Providers" in the "How Your Claims Are Paid" section. You will still be responsible for any applicable Coinsurance, Copayment or Deductible.

If You are admitted to the Hospital from the Emergency Room, be sure that You or Your doctor calls Us as soon as possible. We will review Your care to decide if a Hospital stay is needed and how many days You should stay. If You or Your doctor does not call Us, You may have to pay for services that are determined to be not Medically Necessary.

Treatment You get after Your condition has stabilized and You are able to travel to an in-network Provider or Facility located within a reasonable travel distance using non-medical or nonemergency medical transport is not Emergency Care. If You continue to get care from an out-of-network Provider, Covered Services will not be available unless We agree to cover them as an Authorized Service.

## Habilitative Services

Habilitative Services are healthcare services and devices that help You keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, chiropractic/osteopathic/manipulation therapy, and other services for people with disabilities in a variety of Inpatient and/or Outpatient settings.

Please see "Therapy Services Outpatient" later in this section for further details.

## Home Care Services

Benefits are available for Covered Services performed by a Home Health Care Agency or other Provider in Your home. To be eligible for benefits, You must essentially be confined to the home, as an alternative to a Hospital stay, and be physically unable to get needed medical services on an Outpatient basis. Services must be prescribed by a doctor and the services must be so inherently complex that they can be safely and effectively performed only by qualified, technical, or professional health staff.

Covered Services include, but are not limited to:

- Visits by a licensed healthcare professional, including nursing services by an R.N. or L.P.N., a therapist, or home health aide.
- Infusion Therapy; refer to "Therapy Services Outpatient", later in this section for more information.
- Medical / social services.
- Diagnostic services.
- Nutritional guidance.
- Training of the patient and/or family/caregiver.
- Home health aide services. You must be receiving skilled nursing or therapy. Services must be given by appropriately trained staff working for the home healthcare Provider. Other organizations may give services only when approved by Us, and their duties must be assigned and supervised by a professional nurse on the staff of the home healthcare Provider.
- Medical supplies.
- Durable medical equipment.
- Physical, Speech, and Occupational Therapy Services (except for Manipulation Therapy which will not be covered when given in the home).
- Private duty nursing in the home by a licensed R.N., L.P.N., or L.V.N.

- Intermittent care provided in home, or through remote patient monitoring via telemedicine 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.

Covered services and supplies are those listed below 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.

- 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 and homemaker services 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 pain management and for the palliative treatment of Your condition including oxygen and related respiratory therapy supplies.
- Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Member's death. Bereavement services are available to surviving Members of the immediate family for one Year after the Member's death. Immediate family means Your spouse, children, stepchildren, parents, brothers and sisters.

In order to receive Hospice benefits (1) Your doctor and the Hospice medical director must certify that You are terminally ill and have approximately 12 months to live, and (2) Your doctor must consent to Your care by the Hospice and must be consulted in the development of Your treatment plan. You may access Hospice care while also participating in a clinical trial or continuing disease modifying therapy, as ordered by Your treating Provider. Disease modifying therapy treats the underlying terminal illness. The Hospice must maintain a written treatment plan on file and furnish to Us upon request.

Covered Services beyond those listed above as ordered by Your treating Provider, may be available while in Hospice and are detailed in other sections of this Evidence of Coverage.

## Hospital Services

### Inpatient Hospital Care

Covered Services include acute care in a Hospital setting. Benefits for room, board, nursing and ancillary services include:

- A room with two or more beds.
- A private room. The most the Plan will cover for private rooms is the Hospital's average semi-private room rate unless it is Medically Necessary that You use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by Us. The unit must have facilities, equipment, and supportive services for intensive care or critically ill patients.
- Routine nursery care for newborns during the mother's normal Hospital stay.
- Meals, special diets.
- General nursing services.
- Operating, childbirth, and treatment rooms and equipment.
- Prescribed Drugs.
- Anesthesia, anesthesia supplies and services given by the Hospital or other Provider.
- Medical and surgical dressings and supplies (including hypodermic needles and syringes), casts, and splints.

- Diagnostic services.
- Therapy services.

**Inpatient Professional Services**

Covered Services include:

- Medical care Visits.
- Intensive medical care when Your condition requires it.
- Treatment for a health problem by a doctor who is not Your surgeon while You are in the Hospital for surgery. Benefits include treatment by two or more doctors during one Hospital stay when the nature or severity of Your health problem calls for the skill of separate doctors.
- A personal bedside exam by another doctor when asked for by Your doctor. Benefits are not available for staff consultations required by the Hospital, consultations asked for by the patient, routine consultations, phone consultations, or EKG transmittals by phone.
- Surgery and general anesthesia.
- Newborn exam. A doctor other than the one who delivered the child must do the exam.
- Professional charges to interpret diagnostic tests such as imaging, pathology reports, and cardiology.

**Outpatient Hospital Care**

Your Evidence of Coverage includes Covered Services in an:

- Outpatient Hospital,
- Freestanding ambulatory surgical center,
- Mental Health and Substance Use Facility,
- Other Facilities approved by Us

Benefits include Facility and related (ancillary) charges, when Medically Necessary, such as:

- Surgical rooms and equipment,
- Prescription Drugs, including Specialty Drugs,
- Anesthesia and anesthesia supplies and services given by the Hospital or other Facility,
- Medical and surgical dressings and supplies (including hypodermic needles and syringes), casts, and splints,
- Diagnostic services,
- Therapy services.

## Maternity and Reproductive Health Services

**Maternity Services**

Covered Services for the Subscriber and covered Dependent(s) include services needed during a normal or complicated pregnancy and for services needed for a miscarriage. Maternity services incurred prior to Your Effective Date are not covered.

Covered maternity services include:

- Professional and Facility services for childbirth, including use of the delivery room, and care for normal deliveries in a Facility or the home, including the services of an appropriately licensed nurse midwife
- Routine nursery care for the newborn during the mother's normal Hospital stay, including circumcision of a covered male Dependent
- Prenatal and postnatal services for the mother (including maternity care and maternity-related check-ups) and prenatal screenings as outlined in "Preventive Care Services".
- Postpartum services, including Inpatient care and home Visit(s)
- Fetal screenings, which are genetic or chromosomal tests of the fetus, as allowed by Us. The term also means anatomical, biochemical or biophysical tests to better define the likelihood of genetic and/or chromosomal anomalies.
- Pregnancy testing
- Anesthesia services to provide partial or complete loss of sensation before delivery

- Postnatal services for the baby, including screenings for blood pressure and hearing, behavioral assessment and measurements; hemoglobinopathies screening; gonorrhea prophylactic medication; hypothyroidism screening and PKU screening
- Dental services and dental appliances furnished to a newborn when required to treat medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia
- Prenatal and Postnatal care services for pregnancy and complications of pregnancy for which hospitalization is required

In the event You have a newborn experiencing a life-threatening emergency condition, You are not required to obtain prior authorization for the inter-hospital transfer of Your newborn or the hospitalized mother of such newborn infant to accompany the infant.

**Note:** Under federal law, We may not limit benefits for any Hospital length of stay for childbirth for the mother or newborn to less than 48 hours after vaginal birth, or less than 96 hours after a cesarean section (C-section). However, federal law, as a rule does not stop the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours, or 96 hours, as applicable. In any case, as provided by federal law, We may not require a Provider to get authorization from Us before prescribing a length of stay which is not more than 48 hours for a vaginal birth or 96 hours after a C-section.

Please see "Continuity of Care" in the "How Your Coverage Works" section regarding a request to continue to see the same Provider for services.

**Contraceptive Benefits**

Benefits include oral contraceptive drugs, injectable contraceptive drugs and patches. Benefits also include contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants. Certain contraceptives are covered under the "Preventive Care Services" benefit. Please see that section for further details.

**Sterilization Services**

Benefits for men and women include sterilization services and services to reverse a non-elective sterilization that resulted from illness or injury. Sterilizations for women are covered under the "Preventive Care Services" benefit.

**Abortion Services**

Benefits for abortions in the case of rape or incest, or for a pregnancy which, as certified by a doctor, places the woman in danger of death by a physical disorder, physical illness, or physical injury unless an abortion is performed (i.e., abortions for which federal funding is allowed). This includes a life-threatening physical condition caused by or arising from the pregnancy itself.

**Infertility Services**

Although this Evidence of Coverage offers limited coverage of certain infertility services, it does not cover all forms of infertility treatment. Benefits 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).

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). Fertility treatments such as artificial insemination and in-vitro fertilization are not Covered Services.

## Medical Supplies, Durable Medical Equipment and Appliances

**Durable Medical Equipment and Medical Devices**

Your Evidence of Coverage includes benefits for durable medical equipment and medical devices when the equipment meets the following criteria:

- Is meant for repeated use and is not disposable.
- Is used for a medical purpose and is of no further use when medical need ends.
- Is meant for use outside a medical Facility.

- Is only for the use of the patient.
- Is made to serve a medical use.
- Is ordered by a Provider.

Benefits include purchase-only equipment and devices (e.g., crutches and customized equipment), purchase or rent-to-purchase equipment and devices (e.g., Hospital beds and wheelchairs), and continuous rental equipment and devices (e.g., oxygen concentrator, ventilator, and negative pressure wound therapy devices). Continuous rental equipment must be approved by Us. We may limit the amount of coverage for ongoing rental of equipment. We may not cover more in rental costs than the cost of simply purchasing the equipment.

Benefits include maintenance, repair and replacement costs, except when damage is due to neglect. Benefits also include supplies and equipment needed for the use of the equipment or device, including a battery for a powered wheelchair.

Oxygen and equipment for its administration are also Covered Services. Benefits are also available for nebulizers, traction equipment, and walkers.

**Hearing Supplies**

Benefits are available for members who are certified as deaf or hearing impaired by either a doctor or licensed audiologist. Covered services include:

- Cochlear implants – A surgically implanted device that allows hearing.

**Orthotics and Special Footwear**

When Medically Necessary, benefits are available for:

- Orthotics (braces, boots, splints) for issues resulting from bone deformity, motor impairment, paralysis, or amputation. This includes, but is not limited to, disfigurement caused by cerebral palsy, arthritis, polio, spina bifida, diabetes, accident, injury, or developmental disability, and
- Podiatric devices, such as therapeutic shoes and shoe inserts, to prevent or treat diabetes-related complications.

Covered Services must be ordered by a doctor and include the initial purchase, fitting, adjustment, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part.

**Prosthetics**

Your Evidence of Coverage also includes benefits for prosthetics and components when they are Medically Necessary for activities of daily living which are artificial substitutes for body parts for functional or therapeutic purposes, when they are Medically Necessary for activities of daily living.

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 the prosthetic device.

Benefits include the purchase, fitting, adjustments, repairs and replacements. Covered Services may include, but are not limited to:

- Artificial limbs and accessories;
- One pair of glasses or contact lenses used after surgical removal of the lens(es) of the eyes;
- Breast prosthesis (whether internal or external) after a mastectomy, as required by law;
- Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care;
- Restoration prosthesis (composite facial prosthesis);
- Wigs needed after cancer treatment.

**Medical and Surgical Supplies**

Your Evidence of Coverage includes coverage for medical and surgical supplies that serve only a medical purpose, are used once, and are purchased (not rented). Covered supplies include syringes,

needles, surgical dressings, splints, and other similar items that serve only a medical purpose. Covered Services do not include items often stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

**Diabetic Equipment and Supplies**

Your Evidence of Coverage includes coverage for diabetic equipment and supplies (insulin pump, glucose monitor, lancets and test strips, etc.)

**Blood and Blood Products**

Your Evidence of Coverage also includes coverage for the administration of blood products.

**Hemophilia and Congenital Bleeding Disorders**

Your Evidence of Coverage includes coverage for blood and the administration of blood products for the treatment of 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.

**Medical Formulas**

Your Evidence of Coverage covers special medical formulas as medicine and the medical equipment, supplies, and services that are required to administer the covered formula or enteral nutrition products, including by infusion, which are a critical source of nutrition for covered persons 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 doctor and required to maintain adequate nutritional status.

**Devices and Supplies for Sleep Treatment**

Your Evidence of Coverage 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.

## Mental Health and Substance Use Services

Benefits are available for the diagnosis, crisis intervention and treatment of Mental Disorders and Substance Use Conditions. Mental Health and Substance Use is a condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance use condition. For the purposes of this section the Commission on Accreditation of Rehabilitation Facilities is abbreviated as CARF.

Covered Services include the following:

- Inpatient services in a Joint Commission accredited Hospital or any Facility that We must cover per State law. Inpatient benefits include psychotherapy, group psychotherapy, psychological testing, counseling with family members to assist with the patient's diagnosis and treatment, electroconvulsive therapy, and detoxification, and rehabilitation.
- Outpatient services, including doctor services, in-home and office Visits and treatment in an Outpatient department of a Hospital or Outpatient Facility, such as individual and group psychotherapy, psychological testing, medication management provided in an office setting or in a Joint Commission or CARF-accredited Facility.
- Partial Hospitalization Programs and Intensive Outpatient Programs as defined within this Evidence of Coverage.
- Virtual Visits as described under "Doctor (Physician) Visits" subsection.
- Residential Treatment which is specialized 24-hour treatment in a licensed Residential Treatment Center accredited by The Joint Commission or CARF. It offers individualized and intensive treatment for substance use and eating disorders and includes:
  - Observation and assessment by a psychiatrist weekly or more often,
  - Rehabilitation, therapy, education, and recreational or social activities.

You can get Covered Services from the following Providers:

- Psychiatrist,
- Psychologist,
- Neuropsychologist,
- Licensed clinical social worker (L.C.S.W.),
- 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.

## Physical Medicine and Rehabilitation Services

Physical medicine and Rehabilitation Services are a structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patient's ability to function as independently as possible; including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and services of a social worker or psychologist.

Physical medicine and rehabilitation involves several types of therapy, not just physical therapy, and a coordinated team approach. The variety and intensity of treatments required is the major differentiation from an admission primarily for physical therapy.

## Preventive Care Services

Preventive care services include screenings and other services for adults and children. All recommended preventive services will be covered as required by the Affordable Care Act (ACA) and applicable State law. This means many preventive care services are covered with no Deductible, Copayments or Coinsurance when You use an in-network Provider.

Certain benefits for Members who have current symptoms or a diagnosed health problem, may be covered under the "Diagnostic Services Outpatient" benefit instead of this benefit, if the coverage does not fall within the state or ACA-recommended preventive services.

Nutritional counseling is covered when received as part of a covered wellness service screening.

Covered Services fall under the following broad groups:

1. Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples include screenings for:
    - Breast cancer,
    - Cervical cancer,
    - High blood pressure,
    - Type 2 Diabetes Mellitus,
    - Cholesterol,
    - Child or adult obesity,
    - Colorectal cancer,
    - Prostate cancer, including digital rectal exam and PSA test.
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 adults, including:
    - Screening for abdominal aortic aneurysm, alcohol misuse, colorectal cancer, high blood pressure, type 2 diabetes, cholesterol, depression, Hepatitis B and C, HIV, lung cancer, obesity, syphilis, and tobacco use,
    - Counseling for alcohol misuse, nutrition, obesity, sexually transmitted infection prevention,
    - Smoking and tobacco cessation products, including nicotine patches and gum when obtained
    - with a Prescription,
    - Aspirin use to prevent cardiovascular disease.
4. Preventive care and screenings for infants, children and adolescents as listed in the guidelines supported by the Health Resources and Services Administration, including:

- Assessments for alcohol and drug use, behavioral, oral health risk,
- Medical history,
- BMI measurement,
- Screenings for autism (18 and 24 months),
- Screenings for blood pressure, cervical dysplasia, depression, development, dyslipidemia,
- hematocrit or hemoglobin, Hepatitis B, HIV, lead, obesity, sexually transmitted infection (STI), tuberculin, hearing and vision,
- Counseling for obesity and STI,
- Fluoride chemoprevention supplements for children without fluoride in their water source,
- Iron supplements for children ages six to 12 months at risk for anemia.

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

    - Women's contraceptives including all FDA-approved contraceptive methods, sterilization treatments, and counseling. Contraceptive coverage includes Generic oral contraceptives as well as other contraceptive medications such as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. Brand Drugs will be covered, as preventive care benefits when Medically Necessary, otherwise they will be covered under the "Prescription Drug Benefit at a Retail, Home Delivery, or Specialty Pharmacy." For FDA-approved, self-administered Hormonal Contraceptives, up to a 12-month supply is covered when dispensed or furnished at one time by a Provider or pharmacist, or at a location licensed or otherwise authorized to dispense drugs or supplies.
    - Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one pump per pregnancy.
    - Certain pregnancy screenings; including, but not limited to, Hepatitis B, Rh incompatibility, urinary tract or other infection, and anemia, along with gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes. Expanded tobacco intervention and counseling for pregnant users is also included.
    - Testing for Human Papillomavirus (HPV) every three Years for women who are 30 or older (including those who are at high risk), regardless of Pap smear results.
    - Annual screening and counseling for sexually transmitted infections (STIs) and Human Immunodeficiency Virus (HIV) for sexually active women.
    - Routine mammogram screenings.
    - Screening and counseling for interpersonal and domestic violence.
    - Well woman Visits, including Visits for contraceptive management.
    - BRCA risk assessment screening and genetic counseling /testing.
    - Breast cancer risk-reducing counseling and medications (chemoprevention) for women who are at increased risk for breast cancer and at low risk for adverse medication effects.
    - Screening for osteoporosis in women aged 65 years and older and in younger women whose fracture risk is equal to or greater than that of a 65-year old white women who has no additional risk factors.

6. Preventive care services for tobacco cessation for Members age 18 and older as recommended by the United States Preventive Services Task Force including:

    - Counseling
    - Prescription Drugs obtained at a Retail or Home Delivery Pharmacy.
    - Nicotine replacement therapy products obtained at a Retail or Home Delivery Pharmacy when prescribed by a Provider, including over-the-counter (OTC) nicotine gum, lozenges and patches.
    - Prescription Drugs and OTC items are limited to a no more than 180 day supply per 365 days.

7. Prescription Drugs and OTC items identified as an A or B recommendation by the United States Preventive Services Task Force when prescribed by a Provider including:

    - Aspirin
    - Folic acid supplement during pregnancy

- Bowel preparations

Please note that certain age and gender and quantity limitations apply.

You may call Member Services at the number on Your Identification Card for more details about these services or view the federal government's web sites:

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

## Rehabilitative Services

Rehabilitative Services are healthcare services that help You keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology, chiropractic/osteopathic/manipulation therapy, and psychiatric rehabilitation services in a variety of Inpatient and/or Outpatient settings. To be Covered Services, Rehabilitative Services must involve goals You can reach in a reasonable period of time.

## Skilled Nursing Facility

When You require Inpatient skilled nursing and related services for convalescent and rehabilitative care, Covered Services are available if the Facility is licensed or certified under State law as a Skilled Nursing Facility. Custodial care is not a Covered Service.

The following items and services will be provided to You as an Inpatient in a skilled nursing bed of a Skilled Nursing Facility:

- 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.

Your Evidence of Coverage 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).

## Surgery

Your Evidence of Coverage covers surgical services, including necessry care and treatment, on an Inpatient or Outpatient basis, including surgeries performed in a doctor's office or an ambulatory surgical center. Covered Services include:

- Medically Necessary accepted operative and cutting procedures;
- Surgeries and procedures to correct medically diagnosed congenital defects and birth or congenital abnormalities that cause functional impairment and congenital abnormalities that cause functional impairment in newborn children;
- Other invasive procedures, such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine;
- Endoscopic exams, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy;
- Treatment of fractures and dislocations;
- Anesthesia and surgical support when Medically Necessary;
- Medically Necessary pre-operative and post-operative care;
- Services rendered by an anesthesiologist;
- Blood and blood products; and
- Medical and surgical dressings and supplies (including hypodermic needles and syringes), casts, and splints.

**Note:** 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.

**Oral Surgery**

Benefits are limited to certain oral surgeries including:

- Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia.
- Maxillary or mandibular frenectomy when not related to a dental procedure.
- Alveolectomy when related to tooth extraction.
- Orthognathic surgery because of a medical condition or injury or for a physical abnormality that prevents normal function of the joint or bone upper and/or lower jaw and is Medically Necessary to attain functional capacity of the affected part.
- Oral/surgical correction of accidental injuries as indicated in the “What is Covered” section.
- Surgical services on the hard or soft tissue in the mouth when the main purpose is not to treat or help the teeth and their supporting structures.
- Treatment of non-dental lesions, such as removal of tumors and biopsies.
- Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

**Reconstructive Surgery**

Benefits include reconstructive surgery to correct significant 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 Evidence of Coverage.

**Note:** This section does not apply to orthognathic surgery.

**Mastectomy Notice**

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 in this Evidence of Coverage.

Hospital admissions for covered radical or modified radical mastectomy for the treatment of breast cancer 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.

## Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

Benefits are available 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 (braces), repair of teeth (fillings), or prosthetics (crowns, bridges, dentures).

## Therapy Services Outpatient

**Physical Medicine Therapy Services**

Your Evidence of Coverage includes coverage for the therapy services described below, and which are provided by a licensed therapist, or other appropriately licensed Provider, acting within the scope of their

license. With respect to Rehabilitative Services, to be a Covered Service, the therapy must improve Your level of function within a reasonable period of time.

Covered Services include:

- **Physical therapy** – The treatment by physical means to ease pain, restore health, and to avoid disability after an illness, injury, or loss of an arm or a leg. It includes hydrotherapy, heat, physical agents, bio-mechanical and neuro-physiological principles and devices, as well as, treatment of lymphedema. It does not include massage therapy services at spas or health clubs.
- **Speech therapy and speech-language pathology (SLP) services** – Services to identify, assess, and treat speech, language, and swallowing disorders in children and adults. Therapy will develop or treat communication or swallowing skills to correct speech impairment.
- **Occupational therapy** – Treatment to restore a physically disabled person's ability to do activities of daily living, such as walking, eating, drinking, dressing, using the toilet, moving from a wheelchair to a bed, and bathing. It also includes therapy for tasks needed for the person's job. Occupational therapy does not include recreational or vocational therapies, such as hobbies, arts and crafts.
- **Chiropractic / Osteopathic / Manipulation therapy** – Includes therapy to treat problems of the bones, joints, and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy also focuses on the joints and surrounding muscles, tendons and ligaments.

**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 affecting 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. Physical, speech and occupational therapy Visits, which are provided as part of Early Intervention Services, do not count toward any annual Visit limits that may otherwise apply.

**Other Therapy Services**

Benefits are also available for:

- **Cardiac Rehabilitation** – Medical evaluation, training, supervised exercise, and psychosocial support to care for You after a cardiac event (heart problem). Benefits do not include home programs, on-going conditioning, or maintenance care.
- **Chemotherapy** – Treatment of an illness by chemical or biological antineoplastic agents administered as part of a doctor's Visit, home care Visit, or at an Outpatient facility for treatment of an illness. See the section "Prescription Drugs Administered by a Medical Provider" for more details.
- **Dialysis** – Services for acute renal failure and chronic (end-stage) renal disease, including hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). Covered Services include dialysis treatments in an Outpatient dialysis Facility or doctor's office.

Covered Services also include home dialysis and training for You and the person who will help You with home self-dialysis and for home equipment and supplies.

- **Infusion Therapy** – Nursing, durable medical equipment and drug services that are delivered and administered to You through an I.V.. Also includes Total Parenteral Nutrition (TPN), Enteral nutrition therapy, antibiotic therapy, pain care and chemotherapy. May include injections (intra-muscular, subcutaneous, continuous subcutaneous). 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. See the section "Prescription Drugs Administered by a Medical Provider" for more details.
- **Pulmonary Rehabilitation** – Includes Outpatient short-term respiratory care to restore Your health after an illness or injury.
- **Radiation Therapy** – Treatment of an illness by X-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources, and other Covered Services), materials and supplies needed, administration and treatment planning.
- **Respiratory/Inhalation Therapy** – Includes the use of dry or moist gases in the lungs, nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.

## Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood

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 Evidence of Coverage.

### Tissue Transplant

Your Plan includes coverage for Medically Necessary tissue transplants and are covered like any other surgery, under the regular Inpatient and Outpatient benefits described elsewhere in this Evidence of Coverage. Tissues include bones, tendons (both referred to as musculoskeletal grafts), cornea, skin, heart valves, nerves and veins.

### Covered Transplant Procedure

A covered transplant procedure is any Medically Necessary human organ and bone marrow/stem cell/cord blood 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.

The initial evaluation, any added tests to determine Your eligibility as a candidate for a transplant by Your Provider, and the collection and storage of bone marrow/stem cells are included in the covered transplant procedure benefit regardless of the date of service.

### Donor Benefits

Benefits for an organ donor are as follows:

- When both the person donating the organ and the person getting the organ are Our covered Members, each will get benefits under their Plan.
- When the person getting the organ is Our covered Member, but the person donating the organ is not, benefits under this Plan are limited to benefits not available to the donor from any other source. This includes, but is not limited to, other insurance, grants, foundations, and government programs.
- If Our covered Member is donating the organ to someone who is not a covered Member, benefits are not available under this Plan.

### Unrelated Donor Searches

Your Plan includes Human Leukocyte Antigen (HLA) testing, also referred to as histocompatibility locus antigen testing, for A, B and DR antigens, for use in bone marrow transplantation per transplant. The testing must be done at an accredited Facility.

When approved by Us, Your coverage includes benefits for unrelated donor searches for bone marrow/stem cell/cord blood transplants performed by an authorized licensed registry for bone marrow/stem cell/cord blood transplants for a covered transplant procedure. Donor search charges are limited to the 10 best matched donors per transplant, identified by an authorized registry.

**Live Donor Health Services**

Medically Necessary charges for the procurement, performed by an authorized licensed registry for bone marrow/stem cell/cord blood transplants, 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. A live donor is a person who provides the organ, part of an organ, or tissue for transplantation while alive to another person.

**Transplant Benefit Period**

The transplant Benefit Period starts one day prior to a covered transplant solid organ procedure and one day prior to high dose chemotherapy or preparative regimen for bone marrow stem cell transplants 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 start on the day of the covered transplant procedure and continue 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. 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. 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.

Precertification is required before We will cover benefits for a transplant. Your doctor must certify, and We must agree, that the transplant is Medically Necessary. Your doctor should send a written request for Precertification to Us as soon as possible to start this process. Please see the “Requesting Approval for Benefits” section for how to obtain Precertification.

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. Travel costs for the donor are covered when We make an exception and approve them in advance of the procedure. If the Member receiving treatment is a

minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. The Member 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.

The human organ and bone marrow/stem cell/cord blood transplant 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 doctor home Visits and Office services depending where the service is performed and are subject to Member Cost Shares.

## Urgent Care Services

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 may include:

- X-ray services;
- Tests such as flu, urinalysis, pregnancy test, rapid strep;
- Laboratory services;
- Stitches for simple cuts;
- Draining an abscess; and
- Urgent Care services received at an Urgent Care Center.

## Vision Correction after Surgery or Accident

Benefits include medical and surgical treatment of injuries and illnesses of the eye. Certain vision screenings required by Federal law are covered under the “Preventive Care” benefit.

In situations such as those defined below, Your 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.

# Prescription Drugs

This section describes how You can obtain covered Prescription Drugs administered by a medical Provider or through a Retail Pharmacy, Our Home Delivery Pharmacy, or Our Specialty Pharmacy. Please see the information below that describes how Prescription Drugs are covered.

## Prescription Drugs Administered by a Medical Provider

Your Plan covers Prescription Drugs, including Specialty Drugs that must be administered to You as part of a doctor's Visit, home care Visit, or at an Outpatient Facility and are Covered Services. This may include drugs for infusion therapy, chemotherapy (administered orally, intravenously or by injection), blood products, certain injectables, and any drug that must be administered by a Provider. This section applies when a Provider orders the drug and a medical Provider administers it to You in a medical setting. Benefits for drugs that You inject or get through Your Pharmacy benefit (i.e., Self-Administered Drugs) are not covered under this section. Benefits for those drugs are described in the "Prescription Drug Benefit at a Retail or Home Delivery Pharmacy" section.

**Important Details About Prescription Drug Coverage**

Your Plan 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 Prescription Drug is eligible for coverage. In order to determine if the Prescription Drug is eligible for coverage, We have established criteria.

The criteria which are called drug edits, may include requirements regarding one or more of the following:

- Quantity, dose, and frequency of administration;
- Specific clinical criteria (including, but not limited to, requirements regarding age, test result requirements, and/or presence of a specific condition or disease);
- Specific Provider qualifications (including, but not limited to, REMS certification (Risk, Evaluation and Mitigation Strategies));
- Step therapy requiring one drug, drug regimen or treatment be used prior to use of another drug, drug regimen or treatment for safety and/or cost-effectiveness when clinically similar results may be anticipated;
- Use of a HealthKeepers Prescription Drug List (a formulary developed by HealthKeepers, which is a list of drugs that have been reviewed and recommended for use based on their quality and cost effectiveness).

**Request for Step Therapy Protocol Exception**

Step therapy is the process of requiring one drug, drug regimen, or treatment be used prior to use of another drug, drug regimen, or treatment. A step therapy protocol means a set sequence in which Prescription Drugs for a specified medical condition and medically appropriate for a particular patient are covered under the Plan.

If You or Your doctor believes the step therapy protocol should be overridden in favor of immediate coverage of the doctor's selected Prescription Drug, please have Your doctor get in touch with Us to request a step therapy exception.

We will act upon requests for step therapy exceptions within 72 hours of receiving the request, including hours on weekends. In cases where 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 Plan), We will respond within 24 hours of receiving the request, including hours on weekends. In both cases, Our response will indicate whether the exception request is approved, denied or requires additional supplementation.

If the step therapy exception request is denied You have the right to file a grievance as outlined in the "If You have a Complaint or an Appeal" section of this Evidence of Coverage.

**Precertification**

Precertification may be required for certain Prescription Drugs to make sure proper use and guidelines

for Prescription Drug coverage are followed. We will give the results of Our decision to both You and Your Provider.

For a list of Prescription Drugs that need Precertification, please call the phone number on the back of Your Identification Card. The list will be reviewed and updated from time to time. Including a Prescription Drug or related item on the list does not guarantee coverage under Your Plan. Your Provider may check with Us to verify Prescription Drug coverage, to find out which drugs are covered under this section and if any drug edits apply.

Please refer to the section "Requesting Approval for Benefits" for more details.

If Precertification is denied, You have the right to file a grievance or Appeal as outlined in the "If You have a Complaint or an Appeal" section of this Evidence of Coverage.

**Designated Pharmacy Provider**

HealthKeepers, in its sole discretion, may establish one or more Designated Pharmacy Provider programs which provide specific Pharmacy services (including shipment of Prescription Drugs) to Members. An in-network Provider is not necessarily a Designated Pharmacy Provider. To be a Designated Pharmacy Provider, the in-network Provider must have signed a Designated Pharmacy Provider Agreement with Us. You or Your Provider can contact Member Services to learn which Pharmacy or Pharmacies are part of a Designated Pharmacy Provider program.

For Prescription Drugs that are shipped to You or Your Provider and administered in Your Provider's office, You and Your Provider are required to order from a Designated Pharmacy Provider. A Patient Care Coordinator will work with You and Your Provider to obtain Precertification and to assist shipment to Your Provider's office.

We may also require You to use a Designated Pharmacy Provider to obtain Specialty Drugs for treatment of certain clinical conditions such as Hemophilia, Cancer, Rheumatoid Arthritis, Crohn's Disease, and Psoriasis. We reserve Our right to modify the list of Prescription Drugs, as well as, the setting and/or level of care in which the care is provided to You. HealthKeepers may, from time to time, change with or without advance notice, the Designated Pharmacy Provider for a drug, if in Our discretion, such change can help provide cost effective, value based and/or quality services.

If You are required to use a Designated Pharmacy Provider and You choose not to obtain Your Prescription Drug from a Designated Pharmacy Provider, You will not have coverage for that Prescription Drug.

However, You will have coverage for Prescription Drugs that are provided by an in-network Provider that is not a Designated Pharmacy Provider if such in-network Provider, non-participating Pharmacy, or its intermediary has notified Us or Our Pharmacy Benefits Manager of its agreement to execute a Designated Pharmacy Provider Agreement applicable to Designated Pharmacy Providers.

You can get the list of the Prescription Drugs covered under this section by calling Pharmacy Member Services at the phone number on the back of Your Identification Card or check Our website at www.anthem.com.

**Therapeutic Substitution**

Therapeutic substitution is an optional program that tells You and Your doctor about alternatives to certain prescribed drugs. We may contact You and Your doctor to make You aware of these choices. Only You and Your doctor can determine if the therapeutic substitute is right for You. For questions or issues about therapeutic drug substitutes, call Pharmacy Member Services at the phone number on the back of Your Identification Card.

## Prescription Drug Benefit at a Retail, Home Delivery, or Specialty Pharmacy

Your Plan also includes benefits for Prescription Drugs You get at a Retail, Home Delivery, or Specialty Pharmacy. We use a Pharmacy Benefits Manager (PBM) to manage these benefits. The PBM has a network of Retail Pharmacies, a Home Delivery 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.

Certain contracted Retail Pharmacies can fill Your Prescription at the same Cost Shares that apply to the Home Delivery Pharmacy level of benefits. Please ask Your Pharmacy if they offer this special arrangement or call Pharmacy Member Services at the phone number on Your ID Card for a list of Retail Pharmacies that offer the Home Delivery Pharmacy level of benefits.

**Note:** Benefits for Prescription Drugs, including Specialty Drugs, which are administered to You by a medical Provider in a medical setting (e.g., doctor's office Visit, home care Visit, or Outpatient Facility) are covered under the "Prescription Drugs Administered by a Medical Provider" benefit. Please read that section for important details.

**Prescription Drug Benefits**

Prescription Drug benefits may require Prior Authorization to determine if Your drugs should be covered. Your in-network Pharmacist will be told if Prior Authorization is required and if any additional details are needed for Us to decide benefits.

**Prior Authorization**

Prior Authorization is the process of getting benefits approved before certain Prescriptions can be filled.

Prescribing Providers must obtain Prior Authorization for drug edits in order for You to get benefits for certain drugs. At times, Your Provider will initiate a Prior Authorization on Your behalf before Your Pharmacy fills Your Prescription. At other times, the Pharmacy may make You or Your Provider aware that a Prior Authorization or other information is needed. In order to determine if the Prescription Drug is eligible for coverage, We have established criteria.

The criteria, which are called drug edits, may include requirements regarding one or more of the following:

- Quantity, dose, and frequency of administration;
- Specific clinical criteria (including, but not limited to, requirements regarding age, test result requirements, and/or presence of a specific condition or disease);
- Specific Provider qualifications (including, but not limited to, REMS certification (Risk, Evaluation and Mitigation Strategies));
- Step therapy requiring one drug, drug regimen or treatment be used prior to use of another drug, drug regimen or treatment for safety and/or cost-effectiveness when clinically similar results may be anticipated;
- Use of a Prescription Drug List (as described below).

You or Your Provider can get the list of the drugs that require Prior Authorization by calling Pharmacy Member Services at the phone number on the back of Your Identification Card or check Our website at www.anthem.com. The list will be reviewed and updated from time to time. Including a Prescription Drug or related item on the list does not guarantee coverage under Your Plan. Your Provider may check with Us to verify Prescription Drug coverage, to find out which drugs are covered under this section and if any Drug edits apply.

HealthKeepers may, from time to time, waive, enhance, change or end certain Prior Authorization and/or alternate benefits, if, in Our sole discretion; such change furthers the provision of cost effective, value based and/or quality services.

If Prior Authorization is denied, You have the right to file a grievance or Appeal as outlined in the "If You have a Complaint or an Appeal" section of this Evidence of Coverage.

**Covered Prescription Drugs**

To be a Covered Service, Prescription Drugs must be approved by the 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. Controlled Substances must be prescribed by a licensed Provider with an active Drug Enforcement Administration (DEA) license.

Benefits are available for the following:

- Prescription Drugs from either a Retail Pharmacy or the 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. Coverage is also provided for up to a 12 month supply of FDA-approved, self-administered Hormonal Contraceptives, when dispensed or furnished at one time by a Provider or pharmacist, or at a location licensed or otherwise authorized to dispense drugs or supplies. Certain contraceptives are covered under the "Preventive Care Services" benefit. Please see that section for more details.
- Special food products or supplements when prescribed by a doctor if We agree they are Medically Necessary.
- Flu Shots (including administration).
- FDA-approved drugs used in the treatment of cancer pain, so long as; the drug is prescribed in compliance with established laws pertaining to patients with intractable cancer pain.

We will not deny 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, if prescribed in compliance with established statutes pertaining to patients with intractable cancer pain.

Benefits will not be denied for any drug prescribed, on an inpatient or outpatient basis, to treat a covered indication so as long as the drug has been approved by the United States Food and Drug Administration for at least one indication and the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.

Additionally, benefits will not be denied for any drug, prescribed on an inpatient or outpatient basis, approved by the United States Food and Drug Administration for use in the treatment of cancer on the basis that the drug has not been approved by the United States Food and Drug Administration for the treatment of specific type of cancer for which the drug has been prescribed, provided the drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the standard reference compendia.

Please see "Experimental or Investigational (Experimental/Investigational)" in the "Definitions" section for additional information about the exception criteria and requirements for these coverage situations.

**Where You Can Get Prescription Drugs**

**In-Network Pharmacy**

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. You will need to pay any Copayment, Coinsurance, and/or Deductible that applies when You get the drug. If You do not have Your Identification Card, the Pharmacy will charge You the full retail price of the Prescription and will 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.

**Note:** If We determine that You may be using Prescription Drugs in a harmful or abusive manner, or with harmful frequency, Your selection of in-network Pharmacies may be limited. If this happens, We may require You to select a single In-Network Pharmacy that will provide and coordinate all future Pharmacy services. Benefits will only be paid if You use the single in-network Pharmacy. We will contact You if We determine that use of a single In-Network Pharmacy is needed and give You options as to which In-Network Pharmacy You may use. If You do not select one of the In-Network Pharmacies We offer within 31 days, We will select a single in-network Pharmacy for You. If You disagree with Our decision, You may ask Us to reconsider it, as outlined in the "If You have a Complaint or an Appeal" section of this Evidence of Coverage.

In addition, if We determine that You may be using Controlled Substance Prescription Drugs in a harmful or abusive manner, or with harmful frequency, Your selection of Providers for Controlled Substance Prescriptions may be limited. If this happens, We may require You to select a single in-network Provider that will provide and coordinate all Controlled Substance Prescriptions. Benefits for Controlled Substance Prescriptions will only be paid if You use the single in-network Provider. We will contact You

if We determine that use of a single in-network Provider is needed and give You options as to which in-network Provider You may use. If You do not select one of the in-network Providers We offer within 31 days, We will select a single in-network Provider for You. If You disagree with Our decision, You may ask Us to reconsider it as outlined in the "If you have a Complaint or an Appeal" section of this Evidence of Coverage.

**Partial Supply of Prescription Drugs**

HealthKeepers shall permit and apply a prorated daily cost sharing rate to Prescriptions that are dispensed by an in-network Pharmacy for a partial supply, if the prescribing Provider or the pharmacist determines the fill or refill to be in Your best interest, and You request or agree to a partial supply for the purpose of synchronizing Your medications. Such a proration shall not occur more frequently than annually.

**Services of Non-Participating Retail Pharmacies**

Notwithstanding any provision in this Evidence of Coverage to the contrary, You have coverage for Outpatient Prescription Drug services, including Specialty Drugs, provided to You by an Out-of-Network Pharmacy, when the Out-of-Network Pharmacy or its intermediary has previously notified the PBM of its agreement to accept terms, conditions, and 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 30 days of being requested to do so in writing by the PBM, unless and until the Pharmacy executes and delivers the agreement.

**Note:** We or Our PBM shall permit prompt electronic or telephonic transmittal of the reimbursement agreement by the Pharmacy and ensure prompt verification to the Pharmacy of the terms of reimbursement.

**Specialty Pharmacy**

We keep a list of Specialty Drugs that may be covered 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. We may require You or Your doctor to order certain Specialty Drugs from the PBM's Specialty Pharmacy.

When You use the PBM's Specialty Pharmacy its patient care coordinator will work with You and Your doctor to get Prior Authorization and to ship Your Specialty Drugs to Your home or Your preferred address. Your patient care coordinator will also tell You when it is time to refill Your Prescription.

You can get the list of covered Specialty Drugs by calling Pharmacy Member Services at the phone number on the back of Your Identification Card or check Our website at www.anthem.com.

**When You Order Your Prescription Through the PBM's Specialty Pharmacy**

You can only have Your Prescription for a Specialty Drug filled through the PBM's Specialty Pharmacy. Specialty Drugs are limited to a 30-day supply per fill. The PBM's Specialty Pharmacy will deliver Your Specialty Drugs to You by mail or common carrier at Your home or a site approved by You.

**Specialty Pharmacy Program**

If You are out of a specialty Drug which must be obtained through the PBM's 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 Copayment/Coinsurance, if any.

If You order Your Specialty Drug through the PBM's Specialty Pharmacy and it does not arrive, if Your doctor 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 an In-Network Pharmacy near You. A Member Services

representative from the PBM's Specialty Pharmacy will coordinate the exception and You will not be required to pay additional Coinsurance.

**Home Delivery Pharmacy**

The PBM also has a Home Delivery Pharmacy which lets You get certain drugs by mail if You take them on a regular basis (Maintenance Medication). You will need to contact the PBM to sign up when You first use the service. You can mail written Prescriptions from Your doctor or have Your doctor send the Prescription to the Home Delivery Pharmacy. Your doctor may also call the Home Delivery Pharmacy. You will need to send in any Copayments, Deductible, or Coinsurance amounts that apply when You ask for a Prescription or refill.

**Maintenance Medication**

A Maintenance Medication is a Drug You take on a regular basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If You are not sure the Prescription Drug You are taking is a Maintenance Medication, please call Pharmacy Member Services at the number on the back of Your Identification Card or check Our website at www.anthem.com for more details.

When using Home Delivery, 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 Home Delivery program, You can call Pharmacy Member Services toll-free at 1-833-236-6196.

The Prescription must state the dosage and Your name and address; it must be signed by Your doctor.

The first Home Delivery 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 Home Delivery 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 Home Delivery Prescription Drug program.

**Note:** Some Prescription Drugs and/or medicines are not available or are not covered for purchase through the Home Delivery Prescription Drug program including, but not limited to, antibiotics, Drugs not on the Prescription Drug List, Drugs and medications to treat Infertility, impotence and/or sexual dysfunction, injectables, including self-administered injectables except Insulin. Please check with the Home Delivery Prescription Drug program Member Services department at 1-833-236-6196 for availability of the Drug or medication.

**What You Pay for Prescription Drugs**

**Tiers**

Your share of the cost for Prescription Drugs may vary based on the tier the Drug is in.

- **Tier 1** - Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single-source Brand Drugs, Biosimilars, Interchangeable Biologic Products, or multi-source Brand Drugs.

  Certain low cost drugs, on Tier 1, may be available to Members at no Cost Share. These drugs are listed on Our Prescription Drug List (formulary).

- **Tier 2** - Drugs have a higher Coinsurance or Copayment than those in Tier 1. This tier may contain preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.

- **Tier 3** - Drugs have a higher Coinsurance or Copayment than those in Tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.

- **Tier 4** - Drugs have a higher Coinsurance or Copayment than those in Tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source, Biosimilars, Interchangeable Biologic Product or multi-source Brand Drugs.

**Prescription Drug List**

We also have a Prescription Drug List (a formulary) which is a list of drugs that have been reviewed and recommended for use based on their quality and cost effectiveness. Benefits may not be covered for certain drugs if they are not on the Prescription Drug List.

The Prescription 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 List, please refer to Our website at www.anthem.com or by viewing http://www.anthem.com/VASelectdrugtier4.

We retain the right, at Our discretion, to decide coverage based upon medication dosages, dosage forms, manufacturer and administration methods (i.e., oral, injected, topical, or inhaled) and may cover one form instead of another as Medically Necessary.

This Plan limits Prescription Drug coverage to those Prescription 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 Prescription Drugs if they are not on the Prescription Drug List. Generally, it includes select Generic Drugs with limited Brand Drug coverage. This list is subject to periodic review and modification by HealthKeepers. We may add or delete Prescription Drugs from this Prescription Drug List from time to time. If the change to the formulary results in the removal of a drug from the formulary or movement to a higher tier, 30 days prior notice of the change will be provided to affected Members. Inclusion of a drug or related item on the covered Prescription Drug List is not a guarantee of coverage. A description of the Prescription Drugs that are listed on this Prescription Drug List is available upon request and at www.anthem.com or by viewing http://www.anthem.com/VASelectdrugtier4.

**Exception Request for a Drug not on the Prescription Drug List**

If You or Your doctor believes 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 business day of receipt of the request. We will cover the Prescription Drug only if We agree that it is Medically Necessary and appropriate over the other drugs that are on the Prescription Drug 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 External Review provision of the “If You have a Complaint or an Appeal” section this Evidence of Coverage. The independent external reviewer will make a coverage decision within 72 hours of receiving Your request. If the independent external reviewer approves the coverage of the drug, coverage of the drug will be provided for the duration of Your Prescription, including refills.

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 plan. 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 External Review provision of the “If You have a Complaint or an Appeal” section of this Evidence of Coverage. The independent external reviewer will make a coverage decision within 24 hours of receiving Your request. If the independent external reviewer approves the coverage of the drug, coverage of the drug will be provided for the duration of the exigency.

There are two additional exceptions to the Prescription Drug List requirement:

1. You may obtain coverage without additional cost sharing beyond that which is required of Prescription Drug List drugs for a non-formulary drug if We determine, after consultation with the prescribing doctor, that the Prescription Drug List drugs are inappropriate for Your condition.

2. You may obtain coverage without additional cost sharing beyond that which is required of Prescription Drug List drugs for a non-formulary drug if:
    a. You have been taking or using the non-formulary Prescription Drug for at least six months prior to its exclusion from the Prescription Drug List; and
    b. The prescribing doctor determines that either the Prescription Drug List drugs are inappropriate therapy for Your condition, or that changing drug therapy presents a significant health risk.

We will act on such requests stated in items 1 and 2 above within 24 hours of the receipt of an urgent request, and one business day of the receipt of a standard request.

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 Plan.

**Drug Utilization Review**

If there are patterns of over utilization or misuse of drugs, We will notify Your personal doctor and Your pharmacist. We reserve the right to limit benefits to prevent over utilization of Drugs.

**Additional Features of Your Prescription Drug Pharmacy Benefit**

**Day Supply and Refill Limits**

Certain day supply limits apply to Prescription Drugs as listed in the "Schedule of Cost Share and Benefits." In most cases, You must use a certain amount of Your Prescription before it can be refilled. In some cases We may let You get an early refill. For example, We may let You refill Your Prescription early if it is decided that You need a larger dose. We will work with the Pharmacy to decide when this should happen.

If You are going on vacation and You need more than the day supply allowed, You should ask Your pharmacist to call Our PBM and ask for an override for one early refill. If You need more than one early refill, please call Pharmacy Member Services at the number on the back of Your Identification Card.

**Therapeutic Substitution**

Therapeutic substitution is an optional program that tells You and Your doctor about alternatives to certain prescribed Drugs. We may contact You and Your doctor to make You aware of these choices. Only You and Your doctor can determine if the therapeutic substitute is right for You. For questions or issues about therapeutic Drug substitutes, call Pharmacy Member Services at the phone 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. 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 Pharmacy 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 Prescription Drug List.

**Rebate Impact on Prescription Drugs You Get at Retail or Home Delivery Pharmacies**

HealthKeepers and/or its PBM may also, from time to time, enter into agreements that result in HealthKeepers receiving rebates or other funds ("rebates") directly or indirectly from Prescription Drug manufacturers, Prescription Drug distributors or others.

You will be able to take advantage of a portion of the cost savings anticipated by HealthKeepers from rebates on Prescription Drugs purchased by You from Retail, Home Delivery, or Specialty Pharmacies under this section. If the Prescription Drug purchased by You is eligible for a rebate, most of the estimated value of that rebate will be used to reduce the Maximum Allowed Amount for the Prescription Drug. Any Deductible or Coinsurance would be calculated using that reduced amount. The remaining value of that rebate will be used to reduce the cost of coverage for all Members enrolled in coverage of this type.

It is important to note that not all Prescription Drugs are eligible for a rebate, and rebates can be discontinued or applied at any time based on the terms of the rebate agreements. Because the exact value of the ultimate rebate will not be known at the time You purchase the Prescription Drug, the amount the rebate applied to Your claim will be based on an estimate. Payment on Your claim will not be adjusted if the later determined rebate value is higher or lower than Our original estimate.

# Pediatric Dental Care

**Your Dental Benefits.** Dental care treatment decisions are made by You and Your dentist. We cover treatment based on what benefits You have, not whether the care is Medically or Dentally Necessary. Orthodontic care is an exception. We do review those services to make sure they are appropriate. Also, services for tooth reimplantation will be covered if medically necessary.

**Pretreatment Estimates.** When You need major dental care, like crowns, root canals, dentures/bridges, oral surgery, or braces — it is best to go over a care or treatment plan with Your dentist beforehand. It should include a "pretreatment estimate" so You know what it will cost.

You or Your dentist can send Us the pretreatment estimate to get an idea of how much of the cost Your benefits will cover. Then You can work with Your dentist to make financial arrangements, before You start treatment.

**Pediatric Dental Essential Health Benefits.** The following dental care services are covered for members until the end of the month in which they turn 19. All covered services are subject to the terms, limitations, and exclusions of this Evidence of Coverage. See the "Schedule of Cost Share and Benefits" for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

## Diagnostic and Preventive Services

**Oral Exams.** Two oral exams are covered every 12 months, and begin with the eruption of the first tooth. These include Periodic, Comprehensive, Emergency and Oral Evaluation under three years of age.

**Radiographs (X-rays)**

- Bitewings – one series per 12 month period. Does not include vertical bitewings.
- Full mouth (also called complete series) – one time per 60 month period.
- Panoramic – one time per 60 month period.
- Periapicals and extraorals – Covered as needed per diagnosis.
- Occlusal – two radiographs per 12 month period.

**Dental Cleaning (prophylaxis).** Procedure to remove plaque, tartar (calculus), and stain from teeth. Covered two times per 12 months.

**Fluoride Treatment (topical application or fluoride varnish).** Covered two times per 12 month period.

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

**Space Maintainers (fixed unilateral, fixed bilateral, removable unilateral, removable bilateral).** Covered one time per 24 months per tooth per quadrant (unilateral), per arch (bilateral).

**Recement of Space Maintainer**

**Other Adjunctive Diagnostic and Preventive Services**

- Treatment of complications (postsurgical), by report.

**Diagnostic Casts**

## Basic Restorative Services

**Consultations.** Covered when given by a Provider other than Your treating dentist.

**Office Visits** (after regular scheduled hours, no other service provided).

**Hospital Call**

**Therapeutic Parenteral drug injection-multiple injections, Other drugs and/or Medicaments**

**Application of desensitizing medicament**

**Behavior Management, by report**

**Treatment of complications (post-surgical) unusual circumstances**

**Resin Based Composite Resin crown**

**Recement an Inlay, Onlay or Crown**

**Brush biopsy**

**Sedative filling (also called protective restoration)**

**Crown pin retention per tooth**

**Fillings (restorations).** Covered one time per tooth surface in a 12 month period. Fillings are covered when placed on primary or permanent teeth. There are two kinds of fillings covered under this Plan:

- Amalgam. These are silver fillings that are used to restore decayed or fractured posterior (back) teeth.
- Composite Resin. These are tooth-colored fillings that are used to restore decayed or fractured anterior (front) teeth. If You choose to have a composite resin filling placed on a back tooth, We will pay up to the Maximum Allowed Amount for an amalgam filling. You will be responsible to pay for the difference, if the dentist charges more, plus any applicable deductible or coinsurance.

**Emergency Treatment (also called palliative treatment).** Covered for the temporary relief of pain or infection.

**Note:** Local anesthesia is included in the Maximum Allowed Amount for restorative and surgical covered services and is not separately reimbursed.

## Endodontic Services

**Endodontic Therapy**

- Pulp cap (direct or indirect).
- Pulpal therapy. Covered once per tooth per lifetime. Covered for primary teeth only.
- Pulpotomy. Covered once per tooth per lifetime. Covered for primary teeth only. Will not be covered if given with root canal therapy.
- Gross pulpal debridement. Covered on primary or permanent teeth.
- Root canal therapy. Covered once per tooth per lifetime.
- Root canal retreatment. Covered once per tooth per lifetime.

**Other Endodontic Treatments**

- Apexification. Covered once per tooth per lifetime. Coverage includes initial Visit, interim medication replacement (limited to three treatments) and the final Visit.
- Pulpal Regeneration – Limited to once per tooth per lifetime.
- Apicoectomy/periradicular surgery. Covered once per tooth per lifetime.
- Retrograde filling. Covered once per tooth per lifetime.

**Note:** Local anesthesia is included in the Maximum Allowed Amount for restorative and surgical covered services and is not separately reimbursed.

## Periodontal Services

**Full Mouth Debridement.** This is a non-surgical periodontal service to treat diseases of the gums (gingival) and bone that supports the teeth. Covered once per 12 months.

**Complex Surgical Periodontal Care.** These services are surgical treatment for diseases of the gums (gingival) and bone that supports the teeth. Covered for permanent teeth only.

- Bone replacement graft
- Pedicle soft tissue graft.
- Subepithelial connective tissue graft.
- Gingivectomy or gingivoplasty. Covered once per 24 months per quadrant.
- Autogenous and Non-autogenous connective tissue graft.

**Crown Lengthening** - Covered once per lifetime.

**Periodontal Maintenance.** This procedure includes periodontal evaluation, removing bacteria from the

gum pocket areas, measuring the gum pocket areas, and scaling and polishing of the teeth. Any combination of this procedure and dental cleanings (see Diagnostic and Preventive Services above) is covered four times per 12 months.

**Periodontal Scaling and Root Planing.** This is a non-surgical periodontal service to treat disease of the gums (gingival) and bone that supports the teeth. Covered once per quadrant per 24 months.

**Emergency Room Services Provided by Dentist.** Covered only for occlusal orthotic devices.

**Osseous Surgery.** Covered once per quadrant per 60 months.

**Provisional Splinting**

**Gingival flap procedure.** Covered once per 24 months per quadrant.

**Apically positioned flap procedure.** Covered once per 24 months.

**Scaling in Presence of Generalized moderate or severe gingival inflammation**

**Note:** Local anesthesia is included in the Maximum Allowed Amount for restorative and surgical covered services and is not separately reimbursed.

## Oral Surgery Services

**Basic Extractions**

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

**Complex Surgical Extractions.** Surgical removal of 3rd molars is covered only when symptoms of oral pathology exists.

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

**Other Oral Surgery Procedures**

- Incision and drainage of abscess (intraoral soft tissue). Covered once per day.
- Biopsy of oral tissue.
- Alveoloplasty. Covered once per quadrant per lifetime.
- Frenulectomy/Frenuloplasty. Covered once per lifetime.
- Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.
- Removal of odontogenic cyst, tumor, lesion or growth.
- Sinus performation.
- Oroantral fistula closure.
- Mobilization to aid eruption.
- Removal of exostosis (per site), torus palatinus and mandibularis and surgical reduction of tuberosity.
- Occlusal orthotic device, by report.
- Excision of hyperplastic tissue- per arch, pericoronal gingiva.

**Intravenous Conscious and Non-Conscious Sedation, IV Sedation and General Anesthesia.** Covered when given with complex surgical services.

**Note:** Local anesthesia is included in the Maximum Allowed Amount for restorative and surgical covered services and is not separately reimbursed.

## Major Restorative Services

**Onlays or Permanent Crowns.** Covered one time per 60 months. Only covered on a permanent tooth. To be covered, the tooth must have extensive loss of natural structure due to decay or fracture so that another restoration (such as a filling or inlay) cannot be used to restore the tooth. We will pay up to the Maximum Allowed Amount for porcelain/ceramic onlays and one of the following types of crowns: high noble metal, porcelain only or metal/porcelain. If You choose to have another type of crown, You are

responsible to pay for the difference plus any applicable deductible and coinsurance.

**Recement an Onlay or Crown.** Covered six months after initial placement.

**Crown Repair**

**Inlay, Onlay and Veneer repair** necessitated by restorative material failure.

**Core Build Up.** Includes any pins.

**Cast and Prefabricated Post and Core (in addition to crown).**

**Occlusal Guards** hard and soft appliance, full arch (for grinding and clenching of teeth). Covered once per 12 months for hard appliance and once per 12 months for soft appliance for Members age 13 and older.

**Prefabricated, Stainless Steel, or Temporary Crown.** Covered as needed per pathology. A temporary crown is not covered as a separate service when used while waiting for fabrication of a permanent crown, as it is included in the benefit for a permanent crown.

**Labial Veneers.** Covered once per 60 months per tooth. This is considered as an alternate treatment to a full restoration for an endodontically treated tooth.

**Recement cast or prefabricated post and core.**

**Note:** Local anesthesia is included in the Maximum Allowed Amount for restorative and surgical covered services and is not separately reimbursed.

## Prosthodontic Services

**Dentures and Partials (removable prosthodontic services).** Covered one time per 60 months for the replacement of extracted permanent teeth. If You have an existing denture or partial, a replacement is only covered if at least 60 months have passed and it cannot be repaired or adjusted. Immediate complete dentures are covered one time per lifetime.

**Overdentures (complete and partial, upper and lower)** - are covered once per 60 months. They will be paid up to the Maximum Allowed Amount for upper and lower complete dentures and upper and lower cast metal frameworks with resin denture base. You are responsible to pay for any amount over the Maximum Allowed Amount plus any applicable Deductible and Coinsurance.

**Bridges (fixed prosthodontic services, which includes the retainer (a part of the bridge which is cemented to the tooth providing support for the bridge) and pontic (the artificial tooth that replaces a missing tooth).)** Covered one time per five Years for the replacement of extracted permanent teeth. If You have an existing bridge, a replacement is only covered if at least 60 months have passed and it cannot be repaired or adjusted. In order for the bridge to be covered:

- A natural healthy and sound tooth is present to serve as the anterior and posterior retainer.
- There are no other missing teeth in the same arch that have been replaced with a removable partial denture.
- And none of the individual units (teeth) of the bridge has had a crown or cast restoration covered under this Plan in the last five Years.

The Plan will cover the least costly, commonly performed course of treatment. If there are multiple missing teeth, the Plan may cover a partial denture instead of the bridge. If You still choose to get the bridge, You will be responsible to pay the difference in cost, plus any applicable Deductible and Coinsurance.

**Tissue Conditioning**

**Reline (chairside or laboratory).** Covered one time per 24 months as long as the appliance (denture or partial) is the permanent appliance. Covered once six months has passed from the initial placement of the appliance.

**Denture, Partial Denture and Bridge Repair**

**Denture and Partial Denture Adjustments.** Covered once six months has passed from the initial

placement of the denture.

**Partial and Bridge Adjustments.** Covered once six months have passed from the initial placement of the partial or bridge.

**Recementation of Bridge (fixed prosthetic)**

**Feeding aids (maxillofacial prosthetic).**

**Occlusal Orthotic Device.** Covered only for temporomandibular pain, dysfunction or associated musculature.

**Removable and Fixed Appliance Therapy for Harmful Habits** (such as for thumb sucking and tongue thrusting). Covered once per lifetime.

**Note:** Local anesthesia is included in the Maximum Allowed Amount for restorative and surgical covered services and is not separately reimbursed.

## Orthodontic Care

Orthodontic care is the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. Talk to Your dental Provider about getting a pretreatment estimate for Your orthodontic treatment plan, so You have an idea upfront what the treatment and costs will be. You or Your dental Provider should send it to Us so We can help You understand how much is covered by Your benefits.

**Dentally Necessary Orthodontic Care.** This Plan will only cover orthodontic care that is dentally necessary — at least one of these criteria must be present:

- Spacing between adjacent teeth that interferes with Your biting function
- Overbite that causes the lower front (anterior) teeth to impinge on the roof of Your mouth when You bite
- The position of Your jaw or teeth impairs Your ability to bite or chew
- On an objective, professional orthodontic severity index, the condition scores at a level consistent with the need for orthodontic care

**What Orthodontic Care Includes.** Orthodontic care may include the following types of treatment:

- Limited Treatment. A treatment usually given for minor tooth movement and is not a full treatment case.
- Interceptive Treatment (also known as phase I treatment). This is a limited treatment that is used to prevent or lessen the need for more involved treatment in the future.
- Comprehensive or Complete Treatment. A full kind of treatment that includes all radiographs, diagnostic casts and models, orthodontic appliances and office Visits.
- Removable Appliance Therapy (includes appliances for thumb sucking and tongue thrusting). Treatment that uses an appliance that is removable and not cemented or bonded to the teeth.
- Replacement of lost or broken retainer.
- Fixed Appliance Therapy (includes appliances for thumb sucking and tongue thrusting). Treatment that uses an appliance that is cemented or bonded to the teeth. Covered once per lifetime.
- Complex Surgical Procedures. Surgical procedures given for orthodontic reasons, such as exposing impacted or unerupted teeth, or repositioning of the teeth.
- Repair of orthodontic appliance, removable retainers and recement fixed retention.

**How We Pay for Orthodontic Care.** Because orthodontic treatment usually occurs over a long period of time, payments are made over the course of Your treatment. In order for Us to continue to pay for Your orthodontic care You must have continuous coverage under this Evidence of Coverage.

The first payment for orthodontic care is made when treatment begins. Treatment begins when the appliances are installed. Your dental Provider should submit the necessary forms telling Us when Your appliance is installed. Payments are then made at six month intervals until the treatment is finished or coverage under this Evidence of Coverage ends.

If Your orthodontic treatment is already in progress (the appliance has been installed) when You begin

coverage under this Evidence of Coverage, the orthodontic treatment benefit under this coverage will be on a pro-rated basis. We will only cover the portion of orthodontic treatment that You are given while covered under this Evidence of Coverage. We will not pay for any portion of Your treatment that was given before Your effective date under this Evidence of Coverage.

**What Orthodontic Care Does NOT Include.** The following is not covered as part of Your orthodontic treatment:

- Monthly treatment Visits that are billed separately — these costs should already be included in the cost of treatment.
- Orthodontic retention or retainers that are billed separately — these costs should already be included in the cost of treatment. This does not apply for lost or broken retainers.
- Retreatment and services given due to a relapse.
- Inpatient or Outpatient Hospital expenses, unless covered by the medical benefits of this Evidence of Coverage.

# Pediatric Vision Care

These vision care services are covered for Members until the end of the month in which they turn 19. To get the in-network benefit, You must use a Blue View Vision eye care Provider. For help finding one, try "Find a Doctor" on Our website, or call Us at the number on the back of Your ID Card. See the "Schedule of Cost Share and Benefits" to see Your Deductible, Coinsurance, Copayment and other benefit limitations.

**Routine Eye Exam**

This Evidence of Coverage covers a complete routine eye exam with dilation as needed. The exam is used to check all aspects of Your vision.

**Eyeglass Lenses**

Standard plastic (CR39) eyeglass lenses up to 55mm are covered, whether they are single vision, bifocal, trifocal (FT 25-28) or progressive.

There are a number of additional covered lens options that are available through Your Blue View Vision Provider. See the "Schedule of Cost Share and Benefits" for the list of covered lens options.

**Frames**

Your Blue View Vision provider will have a collection of frames for You to choose from. They can tell You which frames are included at no extra charge — and which ones will cost You more.

**Contact Lenses**

Each Year, You get a lens benefit for eyeglass lenses, non-elective contact lenses or elective contact lenses. But You can only get one of those three options in a given Year. Your Blue View Vision Provider will have a collection of contact lenses for You to choose from. They can tell You which contacts are included at no extra charge – and which ones will cost You more.

**Elective contact lenses** are ones You choose for comfort or appearance.

**Non-elective contact lenses** are ones prescribed for certain eye 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
- For patients whose vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

**Note:** We will not pay for non-elective contact lenses for any Member who has had elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

**Low Vision**

Low vision is when You have a significant loss of vision, but not total blindness. Your Plan covers services for this condition when You go to a Blue View Vision eye care Provider who specializes in low vision. They include a comprehensive low vision exam (instead of a routine eye exam), optical/non-optical aids or supplemental testing.

# WHAT IS NOT COVERED (EXCLUSIONS)

In this section You will find a review of items that are not covered by Your Evidence of Coverage. Excluded items will not be covered even if the service, supply, or equipment is Medically Necessary. This section is only meant to be an aid to point out certain items that may be misunderstood as Covered Services. This section is not meant to be a complete list of all the items that are excluded by Your Evidence of Coverage.

We will have the right to make the final decision about whether services or supplies are Medically Necessary and if they will be covered by Your Evidence of Coverage.

The following services are not covered:

- Services rendered by Providers located outside of the United States, unless the services are for Emergency Care, Urgent Care services received from an Urgent Care Center, or ambulance services related to an Emergency for transportation to a Hospital.
- Services by out-of-network Providers unless:
    - the services are for Emergency Care, ambulance services related to an emergency for transportation to a Hospital, or Urgent Care services received at an Urgent Care Center; or
    - the services are approved in advance by Us.

## Medical Services

Your Medical benefits do not cover:

**Abortions.** We do not provide benefits for procedures, equipment, services, supplies, or charges for abortions for which Federal funding is prohibited. Federal funding is allowed for abortions, where a pregnancy is the result of rape or incest, or for a pregnancy which, as certified by a doctor, places the woman in danger of death unless an abortion is performed.

**Affiliated Providers.** Services received from 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.

**After Hours or Holiday Charges.** Additional charges beyond the Maximum Allowed Amount for basic and primary services requested after normal Provider service hours or on holidays.

**Aids for Non-verbal Communication.** Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices approved by HealthKeepers.

**Alternative/Complementary Medicine.** For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermography, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.

**Ambulance.** Usage is not covered 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 doctor is not a Covered Service. Non-Covered Services for Ambulance include but are not limited to, trips to:

- A doctor'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 doctor. Air ambulance services are not covered for transport to a Hospital that is not an acute care Hospital, such as a nursing facility or a rehabilitation Facility, doctor's office, or Your home.

**Applied Behavioral Treatment** (including, but not limited to, Applied Behavior Analysis and Intensive Behavior Interventions) unless Medically Necessary.

**Armed Forces/War.** For any illness or injury that is a result of war, declared or undeclared, a nuclear explosion, nuclear accident, release of nuclear energy, a riot, or civil disobedience or occurs while serving in the armed forces.

**Autopsies and Post-mortem Testing.**

**Bariatric Surgery.** 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.

**Before Effective Date or After Termination Date.** Charges for care You get before Your Effective Date or after Your coverage ends, except as written in this Agreement.

**Biofeedback Therapy.** Biofeedback therapy.

**Charges Not Supported by Medical Records.** Charges for services not described in Your medical records.

**Charges Over the Maximum Allowed Amount.** Charges over the Maximum Allowed Amount for Covered Services.

**Clinical Trials.** We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- Any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be a Covered Service under this Plan for non-investigational treatments; or
- 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
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
- Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

**Complications of Non-Covered Services.** Services, supplies or treatment related to or, for problems directly related to a service that is not covered by this Plan. Directly related means that the care took place as a direct result of the non-Covered Service and would not have taken place without the non-Covered Service.

**Complications Resulting from Experimental/Investigative or non-Medically Necessary Services or Treatment.** 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.

**Compound Drugs.** Compound Drugs unless there is at least one ingredient that You need a prescription

for, and the drug is not essentially a copy of a commercially available drug product.

**Corrective Eye Surgery.** For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis, or excimer laser refractive keratectomy.

**Cosmetic Services.** Unless specified as a Covered Service in this Evidence of Coverage. Provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve Your appearance or are furnished for 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 Evidence of Coverage. 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. This Exclusion does not apply to: surgery or procedures to correct deformity caused by disease, trauma, or previous therapeutic process. 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.

**Counseling Services.** Counseling Services and treatment related to religious counseling, marital/relationship counseling, vocational or employment counseling, and sex therapy.

**Court Ordered Care.** For court ordered testing or care, unless the service is Medically Necessary and authorized by Us.

**Custodial Care.** Custodial care, convalescent care or rest cures. This Exclusion does not apply to Hospice services.

**Delivery Charges.** Charges for delivery of Prescription Drugs.

**Dental Braces.** For Dental braces, except as specified as a Covered Service in this Evidence of Coverage.

**Dental Implants.** For Dental implants, except as specified as a Covered Service in this Evidence of Coverage.

**Dental Treatment.** For dental treatment, regardless of origin or cause, except as specified as a Covered Service in this Evidence of Coverage. “Dental treatment” includes, but is not limited to, preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums, including but not limited to:

- extraction, restoration and replacement of teeth.
- medical or surgical treatments of dental conditions.
- services to improve dental clinical outcomes.

Dental treatment for injuries that are a result of biting or chewing is also excluded.

This Exclusion does not apply to services that We must cover by law.

**Dental X-Rays, Supplies and Appliances.** For Dental X-rays, supplies and appliances and all associated expenses, including hospitalization and anesthesia, except as required by law or as specified as a Covered Service in this Evidence of Coverage. The only exceptions to this are for any of the following:

- Transplant preparation.
- Initiation of an immunosuppressive.
- Direct treatment of acute traumatic injury, cancer, or cleft palate.

**Doctor or Other Practitioners' Charges.** Doctor or other practitioners' charges including:

- Surcharges for furnishing and/or receiving medical records and reports.
- Charges for doing research with Providers not directly responsible for Your care.
- Charges that are not documented in Provider records.
- 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 doctor.
- For membership, administrative, or access fees charged by doctors 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.

**Doctor Stand-by Charges.** For stand-by charges of a doctor.

**Donor Searches.** 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 in this Evidence of Coverage.

**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.

**Drugs Over Quantity or Age Limits.** Drugs which are over any quantity or age limits set by the Plan or 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.

**Drugs Prescribed by Providers Lacking Qualifications/Registrations/Certifications.** Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations and/or certifications, as determined by HealthKeepers.

**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).

**Durable Medical Equipment.** 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;
- 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.

**Education/Training.** For services, supplies or room and board for teaching, vocational, or self-training purposes. This includes, but is not limited to, boarding schools and/or the room and board and educational components of a residential program where the primary focus of the program is educational in nature rather than treatment based.

**Emergency Room Services for Nonemergency Care.** Services provided in an Emergency room that do not meet the definition of Emergency. For nonemergency Care please use the closest network Urgent Care Center or Your PCP.

**Exams - Research Screenings.** For examinations relating to research screenings.

**Experimental/Investigative.** 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.

**Eyeglasses/Contact Lenses.** For Prescription, fitting, or purchase of eyeglasses or contact lenses, except as specified as a Covered Service in this Evidence of Coverage. 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.

**Family/Self.** 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.

**Feet - Surgical Treatment.** For surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratosis.

**Foot Care – Routine.** For routine foot care, unless Medically Necessary.

**Genetic Testing and Counseling.** Benefits are not provided for genetic testing or genetic counseling, except as specified as a Covered Service in this Evidence of Coverage.

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

**Growth Hormone Treatment.** Growth Hormone Treatment.

**Gynecomastia.** For surgical treatment of gynecomastia.

**Health Club Memberships and Fitness Services.** Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, or facilities used for physical fitness, even if ordered by a doctor. This exclusion also applies to health spas.

**Hearing Aids, including Bone-anchored Hearing Aids.** Hearing aids or exams to prescribe or fit hearing aids, except as specified as a Covered Service in this Evidence of Coverage. This exclusion does not apply to cochlear implants.

**Home Care.** Unless otherwise listed as a Covered Service in this Evidence of Coverage, We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- services not listed in Your doctor'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);
- food and home delivered meals; and
- custodial care and services.

**Hospital Services.** We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- inpatient private duty nursing;
- guest meals, telephones, televisions, and any other convenience items received as part of Your Inpatient stay;
- care by interns, residents, house doctors, or other facility employees that are billed separately from the facility; or
- a private room unless it is medically necessary and approved by us.

**Hospice Care.** The following services, supplies or care are not covered:

- Services or supplies for personal comfort or convenience.
- Food services, meals, formulas and supplements, except as specified as a Covered Service in this Evidence of Coverage or for dietary counseling, even if the food, meal, formula or supplement is the sole source of nutrition.
- 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.
- Services provided by volunteers.

**Hyperhidrosis.** For treatment of hyperhidrosis (excessive sweating).

**Impotency.** For services and supplies related to 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.

**Incarceration.** 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.

**Infertility Testing and Treatment.** 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).

**In-vitro fertilization (IVF) or pre-implant genetic diagnosis (PGD) of embryos.** Services or supplies for in-vitro fertilization (IVF) or pre-implant genetic diagnosis (PGD) of embryos, whether provided or not provided in connection with infertility treatment.

**Maintenance Therapy.** 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.

The exception to this exclusion is Habilitative Services described earlier in this Evidence of Coverage.

**Manipulation Therapy – Home.** For Manipulation Therapy services rendered in the home, except as specified as a Covered Service in this Evidence of Coverage.

**Medical Chats Not Provided Through Our Mobile App.** Texting or chat services provided through a service other than Our mobile app, website, or HealthKeepers-enabled devices.

**Medical Equipment, Devices, and Supplies.** We do not provide benefits for supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in your situation. Reimbursement will be based on the Maximum Allowed Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowed Amount for the standard item which is a Covered Service is Your responsibility.

**Medicare Benefits.** (1) for benefits which are payable for the Member enrolled in Medicare under Medicare Parts A, B and/or D, unless prohibited by law. (2) for 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.

**Missed/Cancelled Appointments.** For missed or cancelled appointments.

**No Legal Obligation to Pay.** For which You have no legal obligation to pay in the absence of this or like coverage.

**Non-approved drugs.** Drugs not approved by the FDA.

**Non Authorized Travel Related Expenses.** For mileage, lodging and meals costs, and other Member travel related expenses, except as authorized by Us or as specified as a Covered Service in this Evidence of Coverage.

**Not Medically Necessary.** Any services or supplies which are not Medically Necessary.

**Nutritional and Dietary Supplements.** For nutritional and dietary supplements, except as specified as a Covered Service in this Evidence of Coverage 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.

**Off Label Use.** Off label use, unless We must cover the use by law or if We approve it.

**Oral Appliances for Snoring.** Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.

**Orthotic Devices, Shoes or Shoe Inserts.** Benefits are not provided for orthotic devices, shoes or shoe inserts, except as specified as a Covered Service in this Evidence of Coverage. We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- Repair and replacement due to misuse, malicious breakage or gross neglect.
- Replacement of lost or stolen items.

**Outdoor Treatment Camps and/or Programs and/or Wilderness Programs.** However, licensed professional counseling provided as a part of these programs is considered a Covered Service.

**Over-the-Counter.** 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, except as specified as a Covered Service in this Evidence of Coverage or as required by law.

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

**Personal Care, Convenience and Mobile/Wearable Devices.** 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 doctor. This exclusion also applies to health spas or similar facility.
- Special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program;
- Charges from a health spa or similar facility;
- 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;
- Infant helmets to treat positional plagiocephaly, unless Medically Necessary;
- Consumer wearable/personal mobile devices (such as a smart phone, smart watch, or other personal tracking devices), including any software or applications;
- Residential, auto, or place of business structural changes (ramps, lifts, elevator chairs, escalators, elevators, stair glides, emergency alert equipment, handrails);
- Safety helmets for Members with neuromuscular diseases; or
- Sports helmets.

**Physical exams and immunizations - other purposes.** Physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.

**Private Duty Nursing.** For Private Duty Nursing Services, except as specified as a Covered Service in this Evidence of Coverage.

**Provider Services.** You get from Providers that are not licensed by law to provide Covered Services, as defined in this Evidence of Coverage. Examples of such Providers may include, but are not limited to, masseurs or masseuses (massage therapists) and physical therapist technicians.

**Provider Type.** Received from an individual or entity that is not a Provider, as defined in this Evidence of Coverage, or recognized by Us.

**Reconstructive Services.** Reconstructive services, except as specified as a Covered Service in this Evidence of Coverage, or as required by law.

**Residential Accommodations.** Residential accommodations to treat medical or behavioral health conditions, except when provided in a Hospital, Hospice, Skilled Nursing Facility, or Residential

Treatment Center. This Exclusion includes procedures, equipment, services, supplies or charges for the following:

- 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.
- 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.
- Services or care provided or billed by a school, custodial care center for the developmentally disabled, or outward bound programs.

**Residential Care.** Unless specified as a Covered Service in this Evidence of Coverage, 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 doctor Visits, daily assessments, and structured therapeutic services.

**Residential Treatment Center.** 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.

**Reversal of Sterilization.** Services to reverse elective sterilization.

**Riot, Nuclear Explosion.** For a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion or nuclear accident.

**Routine Vision Care and Materials.** Routine vision care and materials, except as specified as a Covered Service in this Evidence of Coverage.

**Self-Help Training/Care.** For self-help training and other forms of non-medical self care, except as specified as a Covered Service in this Evidence of Coverage.

**Services.** Services needed for employment or given by a medical department, clinic, or similar service provided or maintained by the employer or any government entity.

**Services for Charges Not Usually Made.** 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 healthcare coverage.

**Services Not Appropriate for Virtual Visits.** Services that We determine require in-person contact and/or equipment that cannot be provided remotely.

**Services, Supplies, or Devices.** We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- received from an individual or entity that is not a Provider, as defined in this Evidence of Coverage, or recognized by Us;
- separate charges for services by healthcare professionals employed by a Facility, which makes their services available;
- not listed as covered under this Evidence of Coverage;
- not prescribed, performed, or directed by a Provider licensed to do so.

We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- amounts above the Maximum Allowed Amount for a service;
- neurofeedback and related diagnostic tests;
- the following therapies:
    - group speech therapy; or
    - group or individual exercise classes or personal training sessions.

**Shock Wave Treatment.** Extracorporeal Shock Wave Treatment for plantar fasciitis and other

musculoskeletal conditions.

**Skilled Nursing Facility.** We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- 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.

**Spinal Manipulation and Manual Medical Therapy Services.** Unless specified as a Covered Service in this Evidence of Coverage, We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- 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.

**Surrogate Pregnancy.** Services or supplies provided to a person not covered under the Evidence of Coverage in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

**Teeth - Congenital Anomaly.** Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly, except as specified as a Covered Service under Surgery, Reconstructive Surgery and Oral Surgery in this Evidence of Coverage or as required by law.

**Teeth, Jawbone, Gums.** 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 as specified as a Covered Service in this Evidence of Coverage.

**Temporomandibular or Craniomandibular Joint Disorder.** Temporomandibular Joint Disorder (TMJ). Covered services do not include fixed or removable appliance that involve movement or repositioning of the teeth repair of teeth (fillings) or prosthetics (crown, bridges, dentures), Oral hygiene instructions, Repair or replacement of lost/broken appliances are not a covered benefit, 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.

**Tests associated with the fitting of contact lenses.** Unless otherwise covered under the "Pediatric Vision Care" section, tests associated with the fitting of contact lenses unless the contact lenses are needed due to eye surgery or to treat accidental injury.

**Therapy – Other.** We do not provide benefits for procedures, equipment, services, supplies or charges for the following:

- Gastric electrical stimulation
- Hippotherapy
- Intestinal rehabilitation therapy
- Prolotherapy
- Sensory integration therapy (SIT)

**Transplant: Human Organ and Bone Marrow/Stem Cell/Cord Blood Exclusions.** Non-Covered Services for transportation and lodging include, but are not limited to:

- Child care.
- Meals.
- 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.

**Vein Treatment.** Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.

**Virtual Visits.** Virtual Visits do not include the use of facsimile, audio-only telephone, texting (outside of Our mobile app), electronic mail, or non-secure instant messaging. Benefits also do not include reporting normal laboratory or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to Providers outside Our network, benefit Precertification or Provider to Provider discussions except as approvedunder the "What Is Covered" section.

**Vision Orthoptic Training.** For vision orthoptic training. This exclusion does not apply to Members through the end of the month in which the Member turns age 19.

**Vision Services or Supplies.** Vision services or supplies, unless needed due to eye surgery or accidental injury, or any other vision services, except as specified as a Covered Service in this Evidence of Coverage.

**Waived Copayment, Coinsurance, or Deductible.** For any service for which You are responsible under the terms of this Evidence of Coverage to pay a Copayment, Coinsurance, or Deductible and the Copayment, Coinsurance or Deductible is waived by an out-of-network Provider.

**Weight Loss Programs.** For weight loss programs, whether or not they are pursued under medical or doctor supervision, except as specified as a Covered Service in this Evidence of Coverage. This exclusion includes commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

**Workers' Compensation.** For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Workers' Compensation Act or other similar law. If Workers' 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.

# Prescription Drugs

Your Prescription Drug benefits do not cover:

- Administration Charges for the administration of any drug except for covered immunizations as approved by Us or the PBM.
- An allergenic extract or vaccine.
- Charges Not Supported by Medical Records. Charges for Pharmacy services not related to conditions, diagnoses, and/or recommended medications described in Your medical records.
- Clinically Equivalent Alternatives. Certain Prescription Drugs may not be covered if You could use a clinically equivalent drug, unless required by law. "Clinically equivalent" means drugs that, for most Members, will give You similar results for a disease or condition. If You have questions about whether a certain drug is covered and which drugs fall into this group, please call the number on the back of Your Identification Card, or visit Our website at www.anthem.com.
- Compound Drugs. Compound Drugs unless there is at least one ingredient that You need a prescription for, and the drug is not essentially a copy of a commercially available drug product.
- 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 specified in "Therapy Services Outpatient", or drugs specified "Medical Supplies, Durable Equipment and Appliances" in the "What is Covered" section – they are Covered Services.
- Drugs not approved by the FDA.
- Drugs Over Quantity or Age Limits. Drugs which are over any quantity or age limits set by the Plan or 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.
- Drugs prescribed by Providers Lacking Qualifications/Registrations/Certifications. Prescription Drugs prescribed by a Provider that does not have the necessary qualifications, registrations and/or certifications as determined by HealthKeepers.
- 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 state or federal law when recommended by the U.S. Preventive Services Task Force and prescribed by a doctor.
- Drugs used for cosmetic purposes.
- Items Covered as Durable Medical Equipment (DME). Therapeutic DME, devices and supplies except peak flow meters, spacers, glucose monitors.
- Lost or stolen drugs. Refills of lost or stolen drugs.
- Mail service programs other than the PBM's Home Delivery Mail Service. Prescription Drugs dispensed by any mail service program other than the PBM's Home Delivery Mail Service, unless We must cover them by law.
- Nutritional or Dietary Supplements. Nutritional and/or dietary supplements, except as described in this Evidence of Coverage or that We must cover by law. This exclusion includes, but is not limited to, nutritional formulas and dietary supplements that You can buy over-the-counter and those You can get without a written Prescription or from a licensed pharmacist.
- 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.
- Over-the-Counter Items may not be covered. Drugs, devices and products, or Prescription Drugs with over-the-counter equivalents and any drugs, devices or products that are therapeutically

comparable to an over-the-counter drug, device, or product. This includes Prescription Drugs when any version or strength becomes available over-the-counter.

- Prescription Drugs used to treat infertility.
- Services or Supplies from Family Members. Services prescribed, ordered, referred by or received from a member of Your immediate family, including Your spouse, Domestic Partner, child/stepchild, brother/stepbrother, sister/stepsister, parent/stepparent, in-law, or self.
- Services we conclude are not Medically Necessary. This includes services that do not meet Our medical policy, clinical coverage, or benefit policy guidelines.
- 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.

# Pediatric Dental Care

Your dental care services do not include services incurred for or in connection with any of the items below:

- Dental Care for members age 19 and older, except as specified as a Covered Service in this Evidence of Coverage.
- Dental services or healthcare services not specifically covered under the Evidence of Coverage (including any Hospital charges, Prescription drug charges and dental services or supplies that do not have an American Dental Association Procedure Code), except as specified as a Covered Service in this Evidence of Coverage.
- Services of anesthesiologist, unless required by law.
- General anesthesia when given separate from a covered oral surgery service and/or Medical Necessity has not been demonstrated.
- Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion. This includes increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth and gnathologic recordings.
- Dental services provided solely for the purpose of improving the appearance of the tooth when tooth structure and function are satisfactory and no pathologic conditions (such as cavities) exist.
- Case presentations, office Visits, consultations.
- Incomplete services where the final permanent appliance (denture, partial, bridge) or restoration (crown, filling) has not been placed.
- Enamel microabrasion and odontoplasty.
- Retreatment or additional treatment necessary to correct or relieve the results of treatment previously benefited under the Evidence of Coverage. The exception to this exclusion is for root canal retreatment as specified under “Endodontic Therapy” in the “What’s Covered” section.
- Biological tests for determination of periodontal disease or pathologic agents, except as specified as a Covered Service in this Evidence of Coverage.
- Collection of oral cytology samples via scraping of the oral mucosa, except as specified as a Covered Service in this Evidence of Coverage.
- Separate services billed when they are an inherent component of another covered service.
- Services for the replacement of an existing partial denture with a bridge, unless the partial denture cannot satisfactorily restore the case.
- 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 that is billed separately from a restoration procedure (such as a filling).
- Pulp vitality tests.
- Adjunctive diagnostic tests.
- Incomplete root canals.
- Cone beam images.
- Anatomical crown exposure.
- Temporary anchorage devices.
- Sinus augmentation.
- Oral hygiene instructions.
- Removal of pulpal debridement, pulp cap, post, pins, resorbable or non-resorbable filling materials, nor the procedures used to prepare and place materials in the canals (tooth roots).
- Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
- The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
- For dental services received prior to the effective date of this Evidence of Coverage or received after the coverage under this Evidence of Coverage has ended.
- Dental services given by someone other than a licensed Provider (dentist or doctor) or their employees.
- Services to treat temporomandibular joint disorder (TMJ), except as specified as a Covered

Service in this Evidence of Coverage.

- Implant services, including maintenance or repair to an implant or implant abutment.
- Dental services for which You would have no legal obligation to pay in the absence of this or like coverage.
- 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.

# Pediatric Vision Care

Your vision care services do not include services incurred for or in connection with any of the items below:

- Vision care for members age 19 and older, except as specified as a Covered Service in this Evidence of Coverage.
- 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.
- For services or supplies prescribed, ordered or referred by, or received from a Member of the Member's immediate family, including the Member's spouse or Domestic Partner, child, brother, sister or parent.
- For completion of claim forms or charges for medical records or reports.
- For missed or cancelled appointments.
- For safety glasses and accompanying frames.
- 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, including Inpatient or Outpatient Hospital vision care, except as specified as a Covered Service in this Evidence of Coverage.
- Lost or broken lenses or frames, unless the Member has reached their normal interval for service when seeking replacements.
- For services or supplies not specified as Covered Services in this Evidence of Coverage.
- Cosmetic lenses or options, such as special lens coatings or non-prescription lenses, except as specified as a Covered Service in this Evidence of Coverage.
- For services or supplies combined with any other offer, coupon or in-store advertisement, or for certain brands of frames where the manufacturer does not allow discounts.
- No benefits are available for frames or contact lenses purchased outside of our formulary.
- Services and materials not meeting accepted standards of optometric practice or services that are not performed by a licensed Provider.
- Blended lenses.
- Oversize lenses.
- For sunglasses.

# HOW YOUR CLAIMS ARE PAID

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 the “Schedule of Cost Share and Benefits” section.

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.

## Cost Sharing Requirements

Cost Sharing is how HealthKeepers shares the cost of healthcare services with You. It means what HealthKeepers is responsible for paying and what You are responsible for paying. You meet Your Cost Sharing requirements through Your payment of Copayments, Deductibles and/or Coinsurance (as described below).

HealthKeepers works with doctors, Hospitals, Pharmacies and other healthcare Providers to control healthcare costs. As part of this effort, most Providers who contract with HealthKeepers agree to control costs by giving discounts to HealthKeepers. Most other insurers maintain similar arrangements with Providers.

The contracts between HealthKeepers and Our in-network Providers include a “hold harmless” clause which provides that You cannot be held responsible by the Provider for claims owed by HealthKeepers for healthcare services covered under this Evidence of Coverage.

Covered Services that are not obtained from a PCP, SCP or another in-network Provider, or that are not Authorized Services will not be covered. The only exceptions are Emergency Care, ambulance services related to an Emergency for transportation to a Hospital, or Urgent Care services received at an Urgent Care Center.

## 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 Home Delivery Pharmacy. In some instances, a Copayment may be required before the Deductible for certain Covered Services. Your Copayment responsibility is shown in Your “Schedule of Cost Share and Benefits.” Whether a Copayment applies to a Covered Service, depends on Your Evidence of Coverage’s benefit design.

Copayments do not accumulate towards the Deductible, however Copayments satisfied in a Calendar Year accumulate 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 Share and Benefits” is 20%, You are responsible for 20% of the Maximum Allowed Amount. See the explanation of Maximum Allowed Amount in this section for additional information. Whether a Coinsurance applies to a Covered Service depends on Your Plan’s benefit design.

## Deductible

A Deductible is a specified dollar amount for Covered Services that the Member must pay within each Calendar Year before HealthKeepers reimburses You for Covered Services. A Copayment may be required before the Deductible for certain Covered Services. The Deductible amount is listed in the “Schedule of Cost Share and Benefits” section. A new Deductible applies at the beginning of each Benefit Period.

## Deductible Calculation

Each family Member's Maximum Allowed Amounts for Covered Services is applied to his or her individual Deductible. Once two or more family Members' Maximum Allowed Amounts for Covered

Services combine to equal the family Deductible, then no other individual Deductible needs to be met for that Calendar Year. No one person can contribute more than his or her individual Deductible to the family Deductible.

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.

Generally, Copayments are not subject to and do not apply to the Deductible, however to confirm how Your Plan works, please refer to the "Schedule of Cost Share and Benefits."

## Out-of-Pocket Limit

The Out-of-Pocket Limit for Covered Services is the sum of the Deductible and Copayment/Coinsurance maximums paid in a Benefit Period. The Out-of-Pocket Limit is the most You (or someone on Your behalf) will pay for Covered Services in a Benefit Period, to the extent permitted by federal law and regulation. Once You meet Your Out-of-Pocket Limit, HealthKeepers will cover 100% of the Maximum Allowed Amount for Covered Services for the rest of that Benefit Period.

### Out-of-Pocket Limit Calculation

The Deductible, Coinsurance, and Copayment amounts incurred in a Calendar Year apply to the Out-of-Pocket Limit.

The individual Out-of-Pocket Limit applies to each covered family Member. Once two or more covered family Members' Out-of-Pocket Limits combine to equal the family Out-of-Pocket Limit amount, the Out-of-Pocket Limit will be satisfied for the family for that Calendar Year. No one person can contribute more than his or her individual Out-of-Pocket Limit.

Once the Out-of-Pocket Limit is satisfied, no additional Cost Sharing will be required for the remainder of the Calendar Year.

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 Exceptions

Please read this section very carefully. Not all money that You pay toward Your healthcare costs are counted toward Your Out-of-Pocket Limit.

Amounts You incur towards Your Deductible, Copayments 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 Plan:

- Amounts exceeding the Maximum Allowed Amount;
- Amounts over any Plan maximum or limitation; and/or
- Expenses for services not covered under this Evidence of Coverage.

## Benefit Period Maximum

Some Covered Services have a maximum number of days or Visits that HealthKeepers will allow during a Benefit Period. When the Deductible is applied to a Covered Service that has a maximum number of days or Visits, the maximum benefits may be reduced by the amount applied to the Deductible, whether or not the Covered Service is paid by Us. These maximums apply even if You have satisfied the applicable Out-of-Pocket Limit. See the "Schedule of Cost Share and Benefits" for those services which have a benefit limit.

## 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 a Non-Network Hospital, there is no agreement on the cost of the service and the Member is responsible

for the entire amount the Provider charges.

Below are examples of what criterion is used to determine whether a Hospital is allocated to Tier 1 or Tier 2. In communities where there is only one Hospital, these Hospitals are allocated to Tier 1:

- Total share of payments by region of the State
- 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.

## Balance Billing

In-network Providers are prohibited from balance billing. An in-network Provider has signed an agreement with HealthKeepers to accept Our determination of the Maximum Allowed Amount or reimbursement rate for Covered Services rendered to a Member who is his or her patient. A Member is not liable for any fee in excess of this determination or negotiated fee, except what is due under the Evidence of Coverage, e.g., Deductibles (if any) or Coinsurance.

When You receive Covered Services from an out-of-network Provider, or when services have been previously authorized, You may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. The exception to this is outlined in "Balance Billing by Out-of-Network Providers" in the "How Your Claims Are Paid" section.

## Balance Billing by Out of Network Providers

When You receive Emergency Services, or when You receive covered nonemergency services involving surgical or ancillary services provided by an out-of-network Provider at an in-network Facility, out-of-network Providers subject to the Commonwealth of Virginia's balance billing laws cannot charge You the difference between their bill and the Plan's Maximum Allowed Amount. Under these circumstances, Your Cost Share shall be determined using the Plan's median in-network contracted rate for the same or similar service in the same or similar geographical area. The Plan will provide You with an Explanation of Benefits (EOB) that reflects the Cost Share requirement.

## Maximum Allowed Amount

### General

This provision describes how We determine the amount of reimbursement for Covered Services.

Reimbursement for services rendered by in-network and out-of-network Providers is based on Your Evidence of Coverage's Maximum Allowed Amount for the Covered Service that You receive. Please also see "Inter-Plan Programs" provision for additional information.

The Maximum Allowed Amount for this Evidence of Coverage is the maximum amount of reimbursement We will allow for services and supplies:

- that meet Our definition of Covered Services, to the extent such services and supplies are covered under Your Evidence of Coverage and are not excluded;
- that are Medically Necessary; and
- that are provided in accordance with all applicable pre-authorization, Utilization Review, or other requirements set forth in Your Evidence of Coverage.

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.

Generally, services received from an out-of-network Provider under this Evidence of Coverage are not covered except for Emergency care, or when services have been previously authorized by Us. When

You receive Covered Services from an out-of-network Provider when services have been previously authorized, You may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant. The exception to this is outlined in "Balance Billing by Out-of-Network Providers" in the "How Your Claims Are Paid" section.

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 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.

Likewise, when multiple procedures are performed on the same day by the same doctor or other healthcare professional, We may reduce the Maximum Allowed Amounts 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.

**Non-contracting Inpatient Facilities**

The Maximum Allowed Amount for Inpatient Facility services may be based on a per diem or per case amount. When calculating these amounts, the charges for non-Covered Services are subtracted from the per diem or per case amount. Please see the "Provider Network Status" section that follows for additional information about how these amounts are calculated for Facilities that have not signed any contract with Us and are not in any of Our networks.

**Provider Network Status**

The Maximum Allowed Amount may vary depending upon whether the Provider is an in-network or an out-of-network Provider.

An in-network Provider is a Provider who is in the managed network for this specific product or in other closely managed specialty network, or who has a participation contract with Us. For Covered Services performed by an in-network Provider, the Maximum Allowed Amount for Your Evidence of Coverage is the rate the Provider has agreed with Us to accept as reimbursement for the Covered Services. Because in-network 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 an in-network Provider or visit Our website www.anthem.com.

Providers who have not signed any contract with Us and are not in any of Our networks are out-of-network Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary Providers. If You use an out-of-network Provider, Your entire claim will be denied except for Emergency care, or unless the services were previously authorized by Us.

For Covered Services You receive if previously authorized from an out-of-network Provider, the Maximum Allowed Amount for this Evidence of Coverage will be one of the following as determined by Us:

1. An amount based on Our out-of-network 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: statewide average reimbursement amounts that We previously paid for similar claims in the Commonwealth of Virginia, reimbursement amounts accepted by like/similar Providers, contracted with Us, reimbursement rates accepted by Provider under the last network contract in effect with Us, 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 and/or method of reimbursement used by CMS, HealthKeepers will update such information, 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; or
5. An amount based on or derived from the total charges billed by the out-of-network Provider; or
6. An amount based on the Medicaid fee schedule established by the State. When basing the Maximum Allowed Amount upon the level or method of reimbursement established by the State for Medicaid, HealthKeepers will update such information no less than annually.

Providers who are not contracted for this product, but are contracted for other products with Us are also considered out-of-network. For this Evidence of Coverage the Maximum Allowed Amount for services from these Providers will be one of the methods shown above unless the contract between HealthKeepers and that Provider specifies a different amount.

For services rendered outside HealthKeepers Service Area by out-of-network Providers, claims may be priced using the local Blue Cross and/or Blue Shield plan's non-participating Provider fee schedule/rate or the pricing arrangements required by applicable State or federal law. In certain situations, the Maximum Allowed Amount for out of area claims may be based on billed charges, the pricing We would use if the healthcare services had been obtained within the HealthKeepers Service Area, or a special negotiated price.

Unlike in-network Providers, out-of-network 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. The exception to this is outlined in "Balance Billing by Out-of-Network Providers" in the "How Your Claims Are Paid" section. Choosing an in-network Provider will likely result in lower Out-of-Pocket costs to You. Please call Member Services for help in finding an in-network Provider or visit Our website at www.anthem.com.

Member Services is also available to assist You in determining Your Evidence of Coverage's Maximum Allowed Amount for a particular service from an out-of-network 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 by the Provider.

For Prescription Drugs, the Maximum Allowed Amount is the amount determined by Us using Prescription Drug cost information provided by the PBM.

**Member Cost Share**

For certain Covered Services and depending on Your Plan design, 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).

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 an in-network or out-of-network Provider. Non-Covered Services include services specifically excluded from coverage by the terms of Your Evidence of Coverage, and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, Your

day/Visit limits. The Maximum Allowed Amount for Inpatient Facility services may be based on a per diem or per case amount. When calculating these amounts, the charges for non-Covered Services are subtracted from the per diem or per case amount.

**Authorized Services**

In some circumstances, such as where there is no in-network Provider available for the Covered Service, We may authorize the in-network Cost Share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service You receive from an out-of-network Provider. In such circumstance, You must contact Us in advance of obtaining the Covered Service. We also may authorize the in-network Cost Share amounts to apply to a claim for Covered Services if You receive Emergency services from an out-of-network Provider and are not able to contact Us until after the Covered Service is rendered. If We authorize an in-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 out-of-network Provider's charge. The exception to this is outlined in "Balance Billing by Out-of-Network Providers" in the "How Your Claims Are Paid" section. Please contact Member Services for Authorized Services information or to request authorization.

The following are examples for illustrative purposes only; the amounts shown may be different than this Plan's Evidence of Coverage Cost Share amounts; see Your "Schedule of Cost Share and Benefits" for Your applicable amounts.

**Example:**

You require the services of a specialty Provider; but there is no in-network Provider for that specialty available to You. You contact Us in advance of receiving any Covered Services, and We authorize You to go to an available out-of-network Provider for that Covered Service and We agree that the in-network Cost Share will apply.

Your Plan Evidence of Coverage has a $25 Copayment for in-network Providers for the Covered Service. The out-of-network Provider's charge for this service is $500. The Maximum Allowed Amount is $200.

Because We have authorized the in-network Cost Share amount to apply in this situation, You will be responsible for the in-network Copayment of $25 and We will be responsible for the remaining $175 of the $200 Maximum Allowed Amount.

**Non-Participating Providers and Facilities**

If You go to a non-participating Provider or Facility with the proper authorization, 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-HealthKeepers Provider. Subject to Your right to appeal, Our payment relieves HealthKeepers of any further liability for the service.

## Inter-Plan Arrangements

**Out-of-Area Services**

**Overview**

We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever You access healthcare services outside the geographic area We serve (the "HealthKeepers Service Area"), the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When You receive care outside of the HealthKeepers Service Area, You will receive it from one of two kinds of Providers. Most Providers ("participating Providers") contract with the local Blue Cross and/or

Blue Shield Plan in that geographic area ("Host Blue"). Some Providers ("non-participating Providers") don't contract with the Host Blue. We explain below how We pay both kinds of Providers. HealthKeepers covers only limited healthcare services received outside of the HealthKeepers Service Area. For example, Emergency Care or Urgent Care services received at an Urgent Care Center obtained outside the HealthKeepers Service Area is always covered. Any other services will not be covered when processed through any Inter-Plan Arrangements, unless authorized by HealthKeepers.

**Inter-Plan Arrangements Eligibility – Claim Types**

Most claim types are eligible to be processed through Inter-Plan Arrangements, as described above. Examples of claims that are not included are Prescription Drugs that You obtain from a Pharmacy and most dental or vision benefits.

**A. BlueCard® Program**

Under the BlueCard® Program, when You receive Covered Services within the geographic area served by a Host Blue, We will still fulfill Our contractual obligations. But, the Host Blue is responsible for: (a) contracting with its Providers; and (b) handling its interactions with those Providers.

When You receive Covered Services outside the HealthKeepers Service Area and the claim is processed through the BlueCard® Program, the amount You pay is calculated based on the lower of:

- The billed charges for Covered Services; 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 special arrangements with that Provider. 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 pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price We used for Your claim because they will not be applied after a claim has already been paid.

**B. Special Cases: Value-Based Programs**

**BlueCard® Program**

If You receive Covered Services under a value-based program inside a Host Blue's Service Area, You will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or care coordinator fees that are a part of such an arrangement, except when a Host Blue passes these fees to HealthKeepers through average pricing or fee schedule adjustments. Additional information is available upon request.

**C. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees**

Federal or State laws or regulations may require a surcharge, tax or other fee. If applicable, We will include any such surcharge, tax or other fee as part of the claim charge passed on to You.

**D. Non-participating Providers Outside Our Service Area**

**1. Allowed Amounts and Member Liability Calculation**

When Covered Services are provided outside of HealthKeepers' Service Area by non-participating Providers, We may determine benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable State or federal law. In these situations, the amount You pay for such services as Deductible, Copayment or Coinsurance will be based on that allowed amount Also, You may be responsible for the difference between the amount that the non-participating Provider bills and the payment We will make for the Covered Services as set forth in this paragraph. Federal or State law, as applicable, will govern payments for out-of-network Emergency Services.

**2. Exceptions**

In certain situations, We may use other pricing methods, such as billed charges, the pricing We

would use if the healthcare services had been obtained within the HealthKeepers Service Area, or a special negotiated price to determine the amount We will pay for services provided by non-participating Providers. In these situations, You may be liable for the difference between the amount that the non-participating Provider bills and the payment We make for the Covered Services as set forth in this paragraph. The exception to this is outlined in “Balance Billing by Out-of-Network Providers” in the “How Your Claims Are Paid” section.

**E. Blue Cross Blue Shield Global® Core Program**

If You plan to travel outside the United States, call Member Services to find out Your Blue Cross Blue Shield Global® Core benefits. Benefits for services received outside of the United States may be different from services received in the United States. The plan only covers Emergency Care, including ambulance, and Urgent Care services outside of 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 Blue Cross Blue Shield Global® Core Service Center any time. They are available 24 hours a day, seven days a week. The toll free number is 1-800-810-2583. Or You can call them collect at 1-804-673-1177.

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” section.

**How Claims are Paid with Blue Cross Blue Shield Global® Core**

In most cases, when You arrange Inpatient Hospital care with Blue Cross Blue Shield Global® Core, 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 typically need to pay for the following services up front:

- Doctors services;
- Inpatient Hospital care not arranged through Blue Cross Blue Shield Global® Core; and
- Outpatient services.

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

When You need Blue Cross Blue Shield Global® Core claim forms You can get international claims forms in the following ways:

- Call the Blue Cross Blue Shield Global® Core Service Center at the numbers above; or
- Online at www.bcbsglobalcore.com.

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

## How HealthKeepers Pays a Claim

The Covered Services available under Your Evidence of Coverage 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. Any payments made by HealthKeepers to the Provider or You for Covered Services will discharge HealthKeepers’s obligation to pay for Covered Services. If You disagree with the payments made, You may file an appeal. Please see the "If You Have a Complaint or Appeal" Section. In the event that payment is made directly to You, You have the responsibility to apply this payment to the claim from the out-of-network Provider. 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. Any assignment of coverage, rights, or benefits under this Evidence of Coverage will be void and unenforceable. Notwithstanding any provision in this Evidence of Coverage to the contrary, however, HealthKeepers:

- Will reimburse directly any dentist, oral surgeon or 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 Evidence of Coverage. Each of the components is explained in the provisions above, at the beginning of this section. For the purposes of this provision, Providers, also includes Facilities.

## 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 three 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 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 15 calendar days of receipt of the claim. We may extend this period for another 30 days if We determine it to be necessary because of matters beyond Our control. In the event that this extension is necessary, You will be notified prior to the expiration of the initial 15 day period. If the coverage decision involves a determination of the appropriateness or Medical Necessity of services, We will make Our decision within two working days of Our 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 Evidence of Coverage 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.

## Notice of Claim and Proof of Loss

After You get Covered Services, We must receive written notice of Your claim in order for benefits to be paid. Written notice of claim must be given within 20 days after a covered loss starts or as soon as reasonably possible. The notice can be given to Us at Anthem Operations, P.O. Box 26623, Richmond, VA 23261-6623, or to the Company's agent. Notice should include the name of the Member and the policy number.

- In-network Providers will submit claims for You. They are responsible for ensuring that claims have the information We need to determine benefits. If the claim does not include enough information, We will ask them for more details, and they will be required to supply those details within certain timeframes.
- Out-of-network claims can be submitted by the Provider if the Provider is willing to file on Your behalf. However, if the Provider is not submitting on Your behalf, You will be required to submit the claim. Claim forms are usually available from the Provider. If they do not have a claim form, You can send a written request to Us, or contact Member Services and ask for a claim form to be sent to You. If You do not receive the claim form, You can still submit written notice of the claim without the claim form. The same information that would be given on the claim form must be included in the written notice of claim, including:
  - Name of patient.
  - Patient's relationship with the Subscriber.
  - Identification number.
  - Date, type, and place of service.
  - Your signature and the Provider's signature.

  Written proof must be given within 90 days after such loss. If it was not reasonably possible to give written proof in the time required, We shall not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. In any event, except in the absence of legal capacity, the proof required must be given no later than one year from the time specified.

  The claim must have the information We need to determine benefits. If the claim does not include enough information, We will ask You for more details and inform You of the time by which We need to receive that information. Once We receive the required information, We will process the claim according to the terms of Your Plan.

  **Please note that failure to submit the information We need by the time listed in Our request could result in the denial of Your claim, unless State or federal law requires an extension.** Please contact Member Services if You have any questions or concerns about how to submit claims.

## Time of Payment of Claims

Benefits for any loss covered by this policy will be paid as soon as the Company receives proper written proof.

## Federal/State Taxes/Surcharges/Fees

Federal or State laws or regulations may require a surcharge, tax or other fee. If applicable, We will include any such surcharge, tax or other fee as part of the claim charge passed on to You.

## Right of Recovery and Adjustment

Whenever payment has been made in error, or in excess of the maximum amount of payment necessary to satisfy the provisions of this Plan, We will have the right to recover such payment from You or, if applicable, the Provider or otherwise make appropriate adjustments to claims. In most instances, such recovery or adjustment activity shall be limited to the Calendar Year in which the error is discovered.

We have oversight responsibility of compliance with Provider and vendor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider or vendor resulting from these audits if the return of the overpayment is not feasible. Additionally, We have established recovery and adjustment policies to determine which recoveries and adjustments are to be pursued, when to incur costs and expenses and settle or compromise recovery or adjustment amounts. We will not pursue recoveries for overpayments or adjustments for underpayments if the cost of the activity exceeds the overpayment or underpayment amount. We may not give You notice of overpayments made by Us or You if the recovery method makes providing such notice administratively burdensome.

## Member's Cooperation

Each Member shall complete and submit to the Plan such authorizations, consents, releases, assignments and other documents as may be requested by the Plan in order to obtain or assure reimbursement under Medicare, Worker's Compensation or any other governmental program. Any Member who fails to cooperate may experience a delay in the payment of benefits.

This authorization remains valid until expressly revoked by notifying Us, Our affiliates, agents or designees in writing of such revocation at any time (except to the extent any action has been taken based on this authorization and/or except as release of such information may be required or authorized by law). Refusal to consent to the release of such information to Us, Our affiliates, agents or designees will permit Us to deny claims for benefits. In no event shall the authorization last longer than the term of coverage of this Evidence of Coverage.

## Explanation of Benefits

After You receive medical care, You will generally receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage You receive. The EOB is not a bill, but a statement from Us to help You understand the coverage You are receiving. The EOB shows:

- Total amounts charged for services/supplies received;
- The amount of the charges satisfied by Your coverage;
- The amount for which You are responsible (if any);
- General information about Your Appeals rights and for information regarding the right to bring an action after the Appeals process.

## Payment Owed to You at Death

Benefits will be paid to You. Any other benefits unpaid at death may be paid, at Our option, either to the Your beneficiary or the Your estate.

## Claims Review for Fraud, Waste and Abuse

HealthKeepers has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking Emergency Services, Urgent Care services received in an Urgent Care Center or other services authorized by Us in accordance with this Certificate from

non-participating or out-of-network Providers could be balance billed by the non-participating or out-of-network Provider for those services that are determined to be not payable as a result of these review processes. The exception to this is outlined in “Balance Billing by Out-of-Network Providers” in the “How Your Claims Are Paid” section. 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.

We also may identify certain Pharmacies to review for potential fraud, waste, abuse or other inappropriate activity when claims data suggests there may be inappropriate billing practices. If a Pharmacy is selected, then We may use one or more clinical utilization management strategies in the adjudication of claims submitted by this Pharmacy, even if those strategies are not used for all Pharmacies delivering services to this Plan’s Members.

## Payment Innovation Programs

We pay 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 healthcare 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 a Network Provider’s total compensation to pre-defined quality, cost, efficiency or service standards or metrics. In some instances, 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 healthcare. The Program payments are not made as payment for specific Covered Health Care Services provided to You, but instead, are based on the 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 Network Providers to Us under the Program(s).

# IF YOU ARE COVERED BY MORE THAN ONE POLICY

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

For the purposes of this provision, "Plan" and “Group Coverage” is defined below.

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

A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1) Plan includes: group and individual health insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type health coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental Plan, as permitted by law.
2) Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Group Coverage means:

1) A Plan that is not available to the general public and is obtained and maintained only because of membership in or a connection with a particular organization or group, including blanket coverage; and
2) Group Plan does not include an individually underwritten and issued guaranteed renewable plan.

## Coordination with Group Coverage

Coverage under this Plan is always secondary to any Group Coverage.

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

When this Plan 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 Plans 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 Plans other than Group Coverage

Each non-group Plan determines its order of benefits using the first of the following rules that apply:

**Rule (1) Determining Primary Versus Secondary Coverage for the Insured**

If the Subscriber of this Plan is also the insured of another insurance company's individual Plan, the longer Plan rule applies. This means the Plan, which covered the person longer, pays benefits first as the primary carrier. The Plan, which covered that person for the shorter time, pays benefits as the secondary carrier. If the two individual Plans 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 Plan will be primary.

**Rule (2) 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.

**Rule (3) Dependent Children Dual Coverage and the Birthday Rule**

When Dependent children are enrolled and eligible for coverage by another Plan, the primary Plan will be the Plan 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 Plan would be primary for the children because her birthday falls first in the Calendar Year.

**Rule (4) Dependents of Divorced Parents**

If the parent with custody of the covered children has not remarried, this parent's Plan provides primary benefits and the parent without custody provides secondary benefits.

If the parent with custody has remarried, this parent's Plan still provides primary benefits, the stepparent's Plan provides secondary benefits, and the parent without custody provides any balance of benefits. When there is a divorce decree, which assigns financial responsibility for healthcare of Dependent children, the decree will determine who must provide primary benefits for the children.

**Rule (5) Longer Policy Rule**

If the primary carrier cannot be determined by the above rules, the Plan that has covered the Dependent longer will be the primary Plan. Some insurance companies designate a father's Plan as the primary Plan for children. If We must coordinate coverage with a Plan that follows this rule, the father's Plan will be primary.

## 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 Plan 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

If benefits are 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 health insurance company or HMO; or
- any other private or government payer.

**Underpayments**

If Your HealthKeepers Plan is liable, but payments have been made under any other Plan, 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 Plan and We will no longer be liable under Your HealthKeepers Plan.

## Investigating Other Insurance

From time to time, You will be asked to complete a questionnaire about other healthcare 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 cancelled. This may help to prevent a delay in the payment of benefits under this Plan for the lack of information.

## Coordination with Medicare and Medicaid

Unless federal law requires the Plan to be the primary payor, the benefits under this Plan for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit Members are entitled to under Medicare. Where Medicare is the responsible payor, all amounts for services that have been paid for by Us that should have been paid for by Medicare shall be reimbursed to Us by or on behalf of the Members.

With respect to Medicaid, The Department of Medical Assistance Services is the payor of last resort to any insurer responsible for a health care claim.

# IF YOU HAVE A COMPLAINT OR AN APPEAL

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 Evidence of Coverage 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
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. 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. Pre-service claims are claims for a service where the terms of the Evidence of Coverage 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. 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 doctor, 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 information that You feel HealthKeepers should consider when reviewing Your Appeal.

A written Appeal must state plainly the reason(s) why You disagree with Our claim decision, Our refusal to authorize or cover a requested service or supply, or how We calculated the benefit. The Appeal should include any pertinent documents and medical records not originally submitted with the claim or request for the service or supply and any other information that the Member feels may have a bearing on the decision. Also, please include the following details with Your Appeal if You have them:

- The Member's name, address and phone number;
- The identification number as shown on Your Identification Card (including the three letter prefix);
- The name of the Provider who will or has provided care;
- The date(s) of service;
- The claim or reference number for the specific decision with which You don't agree; and
- Any bills that You have received from the Provider.

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
Attention: Grievances and Appeals
P.O. Box 27401
Richmond, VA 23279

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

**Vision Claims:**
Blue View Vision
Attention: Appeals Department
P.O. Box 1122
Minneapolis, MN 55440-1122

You must file Your Appeal within 180 days of the date You were notified of the Adverse Benefit Determination.

## 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 Evidence of Coverage 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 healthcare professionals who have no association with Us if Our decision involved making a judgment as to the Medical Necessity, appropriateness, healthcare setting, level of care, or effectiveness of the healthcare 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.

**Note:** You will not be required to exhaust the Plan's internal appeal process before seeking an external review of an adverse determination regarding coverage of treatment if the treatment is to treat cancer.

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 doctor certifies, in writing, that the recommended or requested healthcare 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 healthcare 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 doctor certifies, in writing, that the recommended or requested healthcare 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: 1-877-310-6560, 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 1-804-371-9741, from outside Richmond 1-800-552-7945, national toll-free number 1-877-310-6560.

**The Office of the Managed Care Ombudsman**

**If You have any questions regarding an Appeal or grievance concerning the healthcare 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:**

**1-804-371-9741 in Richmond**
**1-877-310-6560 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 healthcare 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: 1-800-955-1819 Richmond Metropolitan Area: 1-804-367-2106

Fax: 1-804-527-4502

E-Mail: mchip@vdh.virginia.gov

## Limitations of Damages

In the event a Member or his or her 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 Evidence of Coverage, 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 Evidence of Coverage 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 legal action may be brought to recover on this policy within 60 days after written proof of loss has been given as required by this policy. No legal action may be brought after three years from the time written proof of loss is required to be given.

## HealthKeepers Continuing Rights

On occasion, We may not insist on Your strict performance of all terms of this Evidence of Coverage. This does not mean We waive or give up any future rights We have under this Evidence of Coverage.

# WHEN MEMBERSHIP CHANGES (ELIGIBILITY)

The benefits, terms and conditions of this Evidence of Coverage 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 Eligibility

To be eligible for membership as a Subscriber under this Evidence of Coverage, the applicant must:

1. Be determined by the Exchange to be a Qualified Individual 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 Commonwealth of Virginia and meet the following applicable residency requirements:

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); and
- Reside in the Service Area applicable to this Evidence of Coverage.

For a Qualified Individual under age 21, the applicant must:

- Not be living in an institution;
- Not be emancipated;
- Not be receiving optional State supplementary payments (SSP); and
- Reside in the Service Area applicable to this Evidence of Coverage.

Agree to pay for the cost of Premium that HealthKeepers requires;

1. Reveal any coordination of benefits arrangements or other health benefit arrangements for the applicant or Dependents as they become effective;
2. Not be incarcerated (except pending disposition of charges);
3. Not be entitled to or enrolled in Medicare Parts A/B, C and/or D.

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. is seeking employment (whether or not currently employed); or
3. has entered with 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 residency requirements.

## Dependent Eligibility

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; or
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 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 Evidence of Coverage, 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; or
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; or
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 impairment. These Dependents must be allowed as a federal tax exemption by the Subscriber or Subscriber's spouse. The Dependent's impairment 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 Dependent. Your failure to provide this information could result in termination of a Dependent's coverage.

Temporary custody is not sufficient to establish eligibility under this Evidence of Coverage.

## Open Enrollment

As established by the rules of the Exchange, Qualified Individuals are only permitted to enroll in a Qualified Health Plan (QHP), during the annual open enrollment period or as an enrollee to add a Qualified Individual to the current QHP during 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 Member or an enrollee who experiences certain qualifying events or changes in eligibility may enroll in or change a Plan, outside of the annual open enrollment period.

Length of special enrollment periods: Unless specifically stated otherwise, a Member or enrollee has 60 calendar days from the date of a qualifying event to select a Plan.

**Qualifying Events**

- A Qualified Individual gains a Dependent or becomes a Dependent through marriage or domestic partnership, birth, adoption or placement for adoption, or placement in foster care;
- An individual, not previously a citizen, national, or lawfully present gains such status;
- Immigration status changed;
- 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 the Department of Health and Human Services (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, provided he or she had Minimum Essential Coverage in effect for one or more days of the 60 days prior to the move;
- 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;
- Involuntary loss of minimum essential coverage for any reason other than fraud, intentional misrepresentation of a material fact or failure to pay premium;
- Loss of minimum essential coverage due to dissolution of marriage;
- Child support order or other court order;
- Death of a family member enrolled under current coverage;
- Victim or dependent of victim of domestic abuse or spousal abandonment (unable to locate spouse after reasonable diligence);
- Release from incarceration;
- New eligibility verification information;
- Medicaid/FAMIS eligibility determination delay; and
- A Qualified Individual newly gains access to an Individual Coverage Health Reimbursement Arrangement (ICHRA) or is newly provided a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA).

If You cannot find Your situation, contact Your agent/broker or call Us. We can only enroll based on events defined by State and/or federal law.

NOTE: Special enrollment for marriage – only applies if at least one spouse was enrolled in Minimum Essential Coverage at least one day in the 60 days before marriage; or lived abroad for one or more days in the 60 days before marriage; or is an American Indian or Alaskan Native.

## 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. To continue coverage beyond the first 31 days, please contact the Exchange within 60 days of the date of birth to add the child to the Subscriber's Evidence of Coverage and you must pay HealthKeepers timely for any additional Premium due.

A child will be considered adopted from the earlier of: (1) placement for adoption; or (2) the date the court enters a decree granting the adoption. 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. When adoptive or parental placement occurs within 31 days of birth, such child shall be considered a newborn child of the Member, covered automatically for the first 31 days. Please contact the Exchange within 60 days of the placement for adoption or date of adoption to add the child to the Subscriber's Evidence of Coverage

and You must pay HealthKeepers timely for any additional Premium due.

## Adding a Child Due to Award of Court-Appointed Guardianship

If a Subscriber or the Subscriber's spouse files an application for appointment of guardianship of a child, an application to cover the child under the Subscriber's Evidence of Coverage 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.

## Court Ordered Health Coverage

If You are required by a court order, as defined by applicable state or federal law, to enroll Your child under this Evidence of Coverage, and the child is otherwise eligible for the coverage, You must request permission from the Exchange for Your child to enroll under this Evidence of Coverage and once approved by the Exchange, We will provide the benefits of this Evidence of Coverage 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 Evidence of Coverage 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. The applicant's Effective Date is determined by the Exchange based on the receipt of the completed enrollment form. Benefits will not be provided until the applicable Premium is paid to HealthKeepers.

Effective dates for special enrollment periods:

1. In the case of birth, adoption or placement for adoption, and placement in foster care, coverage is effective on the date of birth, adoption, placement for adoption or placement in foster care unless the Subscriber timely requests a different Effective Date. 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;
2. In the case of marriage, coverage is effective on the first day of the month after receipt of the application, as long as the application is received within 60 days of the event;
3. In the case where a Qualified Individual loses Minimum Essential Coverage, coverage is effective based on when a complete application is received, which must be within 60 days of the qualifying event; and
4. In the case of new access to an ICHRA or new provision of a QSEHRA, if the Plan selection is made before the day of the triggering event, coverage is effective on the first day of the month following the date of the triggering event or, if the triggering event is on the first day of a month, on the date of the triggering event. If the Plan selection is made on or after the day of the triggering event, coverage is effective on the first day of the month following the Plan selection.

Effective Dates for special enrollment due to 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;
6. Individual who no longer resides, lives or works in the HealthKeepers's Service Area;
7. A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual;

8. Termination of employer contributions; or
9. Exhaustion of COBRA benefits.

Effective Dates for special enrollment due to loss of Minimum Essential Coverage do 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 Evidence of Coverage. 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, changes in income, change of Dependent's impairment 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 or enrolled in 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.

## 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 and understand that all rights to benefits under this Evidence of Coverage are subject to the condition that all such information is accurate. Any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact by the Member may result in termination or rescission of coverage.

# WHEN MEMBERSHIP ENDS (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 at 12:01am on the termination Effective Date if any of the following occurs:

1. The Member terminates his or 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, moves outside the Service Area, 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 or 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;
7. The Member was enrolled in a QHP without his or her knowledge or consent by a third party, including by a third party with no connection with the Exchange; or
8. The QHP Issuer may terminate coverage as permitted by the Exchange. The Member will be notified by the QHP Issuer as required by law.

"Grace Period" refers to either:

1. The three 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 three month grace period; or
2. Any other applicable 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) 14 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 14 days and the Member requests an earlier termination effective date.
2. If the Member is newly eligible for Medicaid, Children's Health Insurance Program (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 Member requests an earlier termination Effective Date.
4. In the case of a termination for non-payment of Premium and the three month grace period required for Members 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 three 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 Member's death. When a Subscriber dies, the surviving spouse or Domestic Partner of the deceased Subscriber, if covered under the Evidence of Coverage, shall become the Subscriber.

"Reasonable notice" is defined as 14 days prior to the requested effective date of termination.

## 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 Issuer 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.

## Reinstatement

HealthKeepers may, upon request within 30 days of the cancel letter print date, allow a one-time reinstatement (with no lapse in coverage) of an enrolled policy that was previously terminated or canceled because payment was not received within the required timeframe or because payment was returned.

## Death of the Insured

In the event of Your death, Your covered spouse and/or dependent children may continue coverage under this policy by notifying Us in writing within 31 days of Your death. Contact our Customer Service unit for additional information.

## Military Service

We do not cover services for injuries or sicknesses sustained while serving in any branch of the Armed Services. Once You inform 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 canceling this policy.

## Rescission

If within two years after the Effective Date of this Evidence of Coverage, 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 Your application, We may terminate or rescind this Evidence of Coverage as of the original Effective Date. Additionally, if within two 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 Dependent 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 Evidence of Coverage.

This Evidence of Coverage 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 Evidence of Coverage. 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.

You will be provided with advance written notice 30 days before Your coverage is retroactively terminated or rescinded. Such notice will contain clear identification of the alleged fraudulent act, practice, or omission or the intentional misrepresentation of material fact; an explanation as to why the act, practice, or omission was fraudulent or was an intentional misrepresentation of a material fact; notice that You or Your authorized representative, prior to the date the advance notice of the proposed rescission ends, may immediately file an internal appeal to request a reconsideration of the rescission; a description of the health carrier's internal appeal process for rescissions, including any time limits applicable to those procedures; and the date when the advance notice ends and the date back to which the coverage will be rescinded.

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 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 Evidence of Coverage 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.

If We elect to discontinue offering all health insurance coverage in the individual market in the State, health insurance coverage may be discontinued by Us only if: (i) We provide notice to the Commission and to each individual of such discontinuation at least 180 days prior to the date of the expiration of such coverage, and (ii) all health insurance issued or delivered for issuance by Us in this State in such market is discontinued and coverage under such health insurance coverage in such market is not renewed.

## 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 may remain in effect and refers to either the three 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 Evidence of Coverage is terminated. In order for a Premium to be considered paid during the grace period, we must receive it by the last day of the grace period. 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 Benefit 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 31 days of the three month grace period. We must pay claims during the first 31 days of the grace period, but may pend claims after the first 31 days subject to HealthKeepers's right to terminate the Evidence of Coverage, 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 first 31 days of the three month grace period.

## Subscriber Does Not Receive APTC

If the Subscriber is not receiving an APTC, this Evidence of Coverage 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 Evidence of Coverage will stay in force unless prior to the date Premium payment is due You give timely written notice to Us that the Evidence of Coverage is to be terminated. If You do not make the full Premium payment during the grace period, the Evidence of Coverage will be terminated on the last day of the grace period. You will be liable to Us for the Premium payment due including 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 Evidence of Coverage 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 cancel or terminate the enrollment of any Member from the Evidence of Coverage by written notice delivered or mailed to Us effective upon receipt, or on such later date as may be specified in the notice. If this happens, no benefits will be provided for Covered Services received after the Member's termination date. In the event of such termination, We will return the unearned portion of any premium paid. The earned premium shall be computed pro rata. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

## Refund of Premium

Upon Termination, We shall return promptly the unearned portion of any Premium paid.

# 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 Plan, or if You have any additional questions You may contact HealthKeepers at the address below or at the telephone number on Your Identification Card.

Address:

HealthKeepers
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, or the Bureau of Insurance, have Your Evidence of Coverage number ready.

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, at the national toll free number (877) 310-6560, or via email at bureauofinsurance@scc.virginia.gov.

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

## 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.

## Changes in Premiums

The Premium rates are guaranteed for the 12 month period following the first day of the Benefit Year.

The Premium for this Evidence of Coverage may change subject to, and as permitted by, applicable law. You will be notified of a Premium change at the address in Our records at least 75 days prior to such change. 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.

Payment of the Premium by the Subscriber shall serve as notice of the Subscriber's acceptance of the change.

## How to Pay Your Premium

After making Your initial Premium payment, You can make future payments by the following methods:

- online at www.anthem.com
- by mail using the address on Your Premium notice
- by authorizing Us to automatically deduct Your Premium payment from Your financial institution account every month
- by using Our mobile application
- pay in person at any approved retailer found on the mobile application

To learn more about any of these options, please contact Member Services at the number on the back of Your Identification Card.

## Electronic Funds Transfer

If You submit a personal check for Premiums payment, You automatically authorize Us to convert that

check into an electronic payment. We will store a copy of the check and destroy the original paper check. Your payment will be listed on the financial institution account statement as an Electronic Funds Transfer (EFT). Converting Your paper check into an electronic payment does not authorize Us to deduct Premiums from Your account on a monthly basis unless You have given Us prior authorization to do so.

## 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 HealthKeepers for any reason.

## Premiums Paid by a Third Party

HealthKeepers will accept Premium payments made on behalf of Subscribers if the Premium is paid by the following persons or entities:

- The Ryan White HIV/AIDS Program;
- Other Federal and State government programs that provide Premium and Cost Sharing support for specific individuals;
- Indian tribes, tribal organizations and urban Indian organizations; or
- A relative or legal guardian on behalf of a Subscriber.

Unless required by law, HealthKeepers does not accept Premium payments from third parties that are not listed above. Examples of third parties from whom HealthKeepers will not accept Premium payments include, but are not limited to, Providers, Hospitals, not-for-profit organizations (including religious organizations) that have or whose primary donors have a financial interest in the benefits of the contract/policy, commercial entities with a direct or indirect financial interest in the benefits of the contract/policy and employers that offer coverage under an employer health plan.

## Policies, Procedures and Pilot Programs

We are able to introduce new policies, procedures, rules and interpretations, as long as they are reasonable. Such changes are introduced to make the Plan more orderly and efficient. Members must follow and accept any new policies, procedures, rules, and interpretations.

Under the terms of the Evidence of Coverage, We have the authority, in Our sole discretion, to introduce or terminate from time to time, pilot or test programs for disease management, care management, case management, clinical quality, wellness or behavioral health initiatives that may result in the payment of benefits not otherwise specified in this Evidence of Coverage. We reserve the right to discontinue a pilot or test program at any time.

Any provision, term, benefit, or condition of coverage and this Evidence of Coverage may be amended, revised, or deleted by Us upon 31 days written notice, except for Deductible increases. You will be notified of a Deductible increase 75 days in advance of the change. No change in the Evidence of Coverage shall be valid unless evidenced by an amendment which is signed by an authorized officer of HealthKeepers and You.

## Confidentiality and Release of Information

Applicable State and federal law requires Us to undertake efforts to safeguard Your medical information.

For informational purposes only, please be advised that a statement describing Our policies and procedures regarding the protection, use and disclosure of Your medical information is available on Our website and can be furnished to You upon request by contacting Our Member Services department.

Obligations that arise under State and federal law and policies and procedures relating to privacy that are referenced but not included in this Evidence of Coverage are not part of the Evidence of Coverage between the parties and do not give rise to contractual obligations.

## Right to Receive and Release Needed Information

Certain facts are needed to apply these rules. We have the right to decide which facts We need.

Subject to applicable privacy restrictions, We may obtain needed facts from, or give them to, any other organization or person. We need not tell You or obtain Your consent to do this. Each person claiming benefits under this Plan must give Us any facts We need to pay the claim.

## Notice of Privacy Practices

We are committed to protecting the confidential nature of Members' medical information to the fullest extent of the law. In addition to various laws governing Member privacy, We have Our own privacy policies and procedures in place designed to protect Member information. We are required by law to provide individuals with notice of Our legal duties and privacy practices. To obtain a copy of this notice, visit Our website or contact Our Member Services department.

## Catastrophic Events

In case of fire, flood, war, civil disturbance, court order, strike, an act of terrorism or other cause beyond Our control, We may be unable to process Your claims on a timely basis. No legal action or lawsuit may be taken against Us due to a delay caused by any of these events. In such an event, however, We shall use reasonable efforts to perform Our respective obligations.

## Refusal to Follow Recommended Treatment

If a Member refuses treatment that has been recommended by Our in-network Provider, the Provider may decide that the Member's refusal compromises the Provider-patient relationship and obstructs the provision of proper medical care. Providers will try to render all necessary and appropriate professional services according to a Member's wishes, when they are consistent with the Provider's judgment. If a Member refuses to follow the recommended treatment or procedure, the Member is entitled to see another Provider of the same specialty for a second opinion. The Member can also pursue the Appeal process.

## Misstatement of Age

If the Premium for this Evidence of Coverage is based on Your age and if Your age has been misstated, the benefits will be those the Premium paid would have purchased at the correct age.

## 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.

## Severability

In the event that any provision in this Evidence of Coverage is declared legally invalid by a court of law or determined to be illegal due to the enactment of new legislation or regulations, such provision will be severable and all other provisions of the Evidence of Coverage will remain in force and effect.

## Unauthorized Use of Identification Card

If You permit Your Identification Card to be used by someone else or if You use the card before coverage is in effect or after coverage has ended, You will be liable for payment of any expenses incurred resulting from the unauthorized use. Fraudulent misuse could also result in termination of the coverage.

## Right to Change Plan

No agent or employee of the Plan or other person, except an authorized officer of the Plan, has authority to waive, even if by providing incomplete or incorrect information, any conditions or restrictions or to change the form or content of this Plan, to extend the time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information. Such changes can be made only through a written endorsement, signed by an officer of the Plan.

## Care Coordination

We pay in-network Providers in various ways to provide Covered Services to You. For example, sometimes We may pay in-network Providers a separate amount for each Covered Service they provide. We may also pay them one amount for all Covered Services related to treatment of a medical condition. Other times, We may pay a periodic, fixed pre-determined amount to cover the costs of Covered Services. In addition, We may pay in-network Providers financial incentives or other amounts to help improve quality of care and/or promote the delivery of healthcare services in a cost-efficient manner, or compensate in-network Providers for coordination of Member care. In some instances, in-network Providers may be required to make payment to Us because they did not meet certain standards. You do not share in any payments made by in-network Providers to Us under these programs.

## 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 / Investigative 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.

## Program Incentives

We may offer incentives from time to time, at Our discretion, in order to introduce You to covered programs and services available under this Plan. We may also offer, at Our discretion, the ability for You to participate in certain voluntary health or condition focused digital applications or use other technology based interactive tool, or receive educational information in order to help You stay engaged and motivated, manage Your health, and assist in Your overall health and well-being. The purpose of these programs and incentives include, but are not limited to, making You aware of cost effective benefit options or services, helping You achieve Your best health, encouraging You to update member-related information and encouraging You to enroll automatically to pay Premiums electronically. These incentives may be offered in various forms such as retailer coupons, gift cards, health related merchandise, and discounts on fees or Member Cost Share. Acceptance of these incentives is voluntary as long as HealthKeepers offers the incentives program. Motivational rewards, awards or points for achieving certain milestones may be a feature of the program. We may discontinue an incentive or a program for a particular covered program or service at any time. If You have any questions about whether receipt of an incentive or retailer coupon results in taxable income to You, We recommend that You consult Your tax advisor.

## Value-Added Programs

We may offer health or fitness related programs and products to Our 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 the Plan 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 Evidence of Coverage 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.

## 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 Plan. 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 Share 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.)

# MEMBER RIGHTS AND RESPONSIBILITIES

As a Member, You have rights and responsibilities when receiving healthcare. As Your healthcare partner, We want to make sure Your rights are respected while providing Your health benefits. That means giving You access to Our network of doctors and other healthcare professionals, who help You make the best decisions for Your health.

**You have the right to:**

- Speak freely and privately with Your doctors and other healthcare professionals about healthcare options and treatment needed for Your condition, no matter what the cost or whether it is covered under Your Plan.
- Work with Your doctors and other healthcare professionals to make choices about Your healthcare.
- 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.
- Receive information You need to fully engage with Your health Plan, and also share Your feedback. This includes:
    - Our company and services;
    - Our network of doctors and other healthcare professionals;
    - Your rights and responsibilities;
    - The way Your health Plan 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 receive in the future. This includes asking Your doctors and other healthcare professionals to tell You how that may affect Your health now and in the future.
- Get the most up-to-date information from a doctor 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 medical benefits under the Plan and ask for help if You have questions.
- Follow all medical Plan rules and policies.
- Choose an in-network Primary Care Physician, also called a PCP, if Your health Plan requires it.
- Treat all healthcare professionals and staff with respect.
- Keep all scheduled appointments. Call Your doctor's office if You may be late or need to cancel.
- Understand Your health challenges as well as You can and work with Your doctors and other healthcare professionals to create an agreed upon treatment plan.
- Inform Your doctors and other healthcare professionals if You do not understand the type of care and Your actions that they are recommending.
- Follow the treatment plan that You have agreed upon with Your doctors and other healthcare professionals.
- Share the information needed with Us, Your doctors, and other healthcare professionals to help You get the best possible care. This may include information about other health insurance benefits You have in addition to Your coverage with Us.
- Inform Member Services if You have any changes to Your name, address or family members covered under Your Plan.

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 are here to provide high-quality benefits and service to Our Members. Benefits and coverage for services given under the Plan are overseen by Your EOC and not by this Member Rights and Responsibilities statement.

# DEFINITIONS

The following terms, defined in this section, are capitalized throughout the Evidence of Coverage so they are easy to identify.

### Advance Payments of the Premium Tax Credit (APTC)

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

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.

### Appeal

A formal request by You or Your representative for reconsideration of a decision not resolved to Your satisfaction or an adverse benefit determination. See the “If You Have a Complaint or an Appeal” section of this Evidence of Coverage.

### Applied Behavioral Analysis

Means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

### Authorized Service

A Covered Service rendered by any Provider other than a Network Provider, which has been authorized in advance (except for Emergency Care which may be authorized after the service is rendered) by Us to be paid at the Network level. For more information, see the “Claim Payments” section.

### Autism Spectrum Disorder

Any pervasive developmental disorder, or Autism Spectrum Disorder, as defined in the most recent edition or the most recent edition at the time of diagnosis of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

For Autism Spectrum Disorder, "Medically Mecessary" means in accordance with the generally accepted standards of mental disorder or condition care and clinically appropriate in terms of type, frequency, site, and duration, based upon evidence and reasonably expected to do any of the following:

- prevent the onset of an illness, condition, injury, or disability;
- reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury, or disability; or
- assist to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and the functional capacities that are appropriate for individuals of the same age.

### Benefit Period/Year

The period of time that We pay benefits for Covered Services. Generally, the Benefit Period/Year is a Calendar Year for this Plan, as listed in the ”Schedule of Cost Share and Benefits”. If Your coverage ends earlier, the Benefit Period/Year ends at the same time.

### Biosimilars

A type of biological product that is licensed (approved) by FDA because it is highly similar to an already

FDA-approved biological product, known as the biological reference product (reference product), and has been shown to have no clinically meaningful difference from the reference product.

### Brand Drugs

Prescription Drugs that we classify as Brand Drugs or Our PBM has classified as Brand Drugs through use of an independent proprietary industry database.

### Calendar Year

A period beginning on January 1 and ending on December 31 of the same Year.

### Coinsurance

The percentage of the Maximum Allowed Amount that You pay for some Covered Services.

### Controlled Substances

Drugs and other substances that are considered controlled substances under the Controlled Substances Act (CSA), which are divided into five schedules.

### Copayment

A fixed amount 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)

The amount which the Member is required to pay for Covered Services. Where applicable, Cost Share can be in the form of Copayments, Coinsurance and/or Deductibles.

### Covered Services

Services, supplies or treatments which are:

- Medically Necessary or otherwise specifically included as a benefit and that is listed under the “What is Covered” section;
- Within the scope of the Provider’s license;
- Rendered while coverage under this Evidence of Coverage is in force;
- Not Experimental or Investigational or not covered by this Evidence of Coverage; and
- Authorized in advance by Us, if such preauthorization is required in this Evidence of Coverage.

### Deductible

The amount of charges You must pay for certain Covered Services before any benefits are available to You under this coverage. Your Deductible is stated in Your “Schedule of Cost Share 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 “Pediatric Dental Care” section for more information.

### Dependent

A Member of the Subscriber’s family who meets the rules listed in the “When Membership Changes (Eligibility)” section and who has enrolled in the Plan.

### Designated Pharmacy Provider

An in-network Pharmacy that has executed a Designated Pharmacy Provider agreement with Us or an in-network Provider that is designated to provide Prescription Drugs, including Specialty Drugs, to treat certain conditions.

### Effective Date

The date when a Member’s coverage begins under this Evidence of Coverage. Coverage begins at 12:01

a.m. on the Effective Date.

### Emergency Medical Condition (Emergency)

Regardless of the Covered Person's final diagnosis, a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:

- placing the mental or physical health of the individual or another person (or, with respect to a pregnant woman, the health of the woman or her fetus) in serious jeopardy;
- serious impairment to bodily functions; or
- serious dysfunction of any bodily organ or part.

### Emergency Services (Emergency Care)

With respect to an Emergency Medical Condition:

1) A medical or behavioral health screening examination that is within the capability of the emergency department of a Hospital or independent freestanding Emergency Facility, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition, and
2) Within the capabilities of the staff and facilities available at the Hospital or Facility, such further medical examination and treatment to Stabilize the patient.

The term "**Stabilize**" means, with respect to an Emergency Medical Condition:

To provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability 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).

### Evidence of Coverage ("EOC")

The agreement, between Us and the Subscriber, which is a summary of the terms of Your benefits. It includes this EOC, Your "Schedule of Cost Share 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 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

A Facility including, but not limited to, a Hospital, freestanding ambulatory surgical or treatment Facility, chemical dependency treatment facility, Residential Treatment Center, Skilled Nursing Facility, Home Health Care Agency, other licensed Inpatient centers, diagnostic, laboratory, and imaging centers, rehabilitation and other therapeutic health settings or mental health Facility, as defined in this Evidence of Coverage. The Facility must be licensed, accredited, registered and approved by the Joint Commission or The Commission on Accreditation of Rehabilitation Facilities (CARF), as applicable, or meet specific rules set by Us.

### Generic/Generic Drugs

Prescription Drugs that we classify as Generic Drugs or that Our PBM 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 Drug.

### Habilitative Services

Healthcare services and devices that help a person 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 Doctor

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 Doctor, 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.

### Home Delivery Pharmacy

A service where You get Prescription Drugs (other than Specialty Drugs) through a mail order service.

### Home Health Care Agency

A Facility, licensed in the state in which it is located, which:

- Provides skilled nursing and other services on a visiting basis in the Member's home; and
- Is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending doctor.

### Hormonal Contraceptives

A medication taken to prevent pregnancy by means of ingestion of hormones, including medications containing estrogen or progesterone, that is self-administered, requires a Prescription, and is approved by the U.S. Food and Drug Administration for such purpose.

### 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 and primarily and continuously engaged in providing or operating, either on its premises or in Facilities available to the Hospital on a prearranged basis and under the supervision of a staff of duly licensed physicians;
3. 24 hour nursing service;
4. All the facilities on site are needed to diagnose, care, and treat an illness or injury, and primarily and continuously engaged in providing or operating, either on its premises or in Facilities available to the Hospital on a prearranged basis and under the supervision of a staff of duly licensed physicians; and
5. Is fully accredited by the Joint Commission.

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

### Identification Card/ID Card

A card issued by the Plan that bears the Member's name, identifies the membership by number, and may contain information about Your coverage. It is important to carry this card with You.

### In-Network Pharmacy

An In-Network Pharmacy is a Pharmacy that has an In-Network Pharmacy agreement in effect with or for Our benefit at the time services are rendered. In-Network Pharmacies may be based on a restricted network, and may be different than the network of In-Network Pharmacies for Our other products. To find an In-Network Pharmacy near You, call Pharmacy Member Services at the telephone number on the back of Your Identification Card.

### Inpatient

A Member who receives care as a registered bed patient in a Hospital or other Facility where a room and

board charge is made. It does not mean a Member who is placed under observation for fewer than 24 hours.

### Intensive Outpatient Program

Structured, multidisciplinary behavioral health treatment that provides a combination of individual, group and family therapy in a program that operates no less than three hours per day, three days per week.

### Interchangeable Biologic Product

A type of biological product that is licensed (approved) by FDA because it is highly similar to an already FDA-approved biological product, known as the biological reference product (reference product), and has been shown to have no clinically meaningful differences from the reference product. In addition to meeting the biosimilarity standard, is expected to produce the same clinical result as the reference product in any given patient.

### Maintenance Medication

A Drug You take on a regular 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 Pharmacy Member Services at the number on the back of Your Identification Card or check Our website at www.anthem.com for more details.

### Maximum Allowed Amount

The maximum amount that We will allow for Covered Services You receive. For more information, see the “How Your Claims Are Paid” Section.

### Medicaid

Title XIX of the United States Social Security Act, Grants to States for Medical Assistance Programs.

### 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.

### Medicare

The programs of healthcare for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

### Member

The Subscriber and enrolled Dependent.

### Mental Health and Substance Use Disorder

A condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health, substance abuse or substance use condition.

### Minimum Essential Coverage

The term Minimum Essential Coverage means any of the following: Government sponsored programs (Medicare, Medicaid, CHIP, TRICARE for Life, veteran's healthcare 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.

### Out of Network Pharmacy

A Pharmacy that does not have an In Network 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 an Out of Network Pharmacy.

### Out-of-Plan Benefits

Are benefits for care received from a non-HealthKeepers Provider.

### Out-of-Pocket Limit

The most You pay in Copayments, Deductibles, and Coinsurance during a Benefit Period for Covered Services. The Out-of-Pocket Limit does not include Your Premium, amounts over the Maximum Allowed Amount, or charges for healthcare that Your Evidence of Coverage doesn't cover. When the Out-of-Pocket Limit is reached, no additional Deductible or Coinsurance is required unless otherwise specified in this Evidence of Coverage. Please see the "Schedule of Cost Share and Benefits" for details.

### Outpatient

A Member who receives services or supplies when not an Inpatient.

### Partial Hospitalization Program

A licensed or approved structured, multidisciplinary day or evening behavioral health treatment program that includes the major diagnostic, medical, psychiatric and psychosocial rehabilitation treatment modalities designed for patients with mental, emotional, or nervous disorders, and alcohol or other drug dependence who require coordinated, intensive, comprehensive and multi-disciplinary treatment. Such a program shall provide treatment over a period of six or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients. Such term shall also include intensive outpatient programs for the treatment of alcohol or other drug dependence which provide treatment over a period of three or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients.

### Pharmacy

A place licensed by State law where You can get Prescription Drugs and other medicines from a licensed pharmacist when You have a Prescription Order from Your doctor.

### Pharmacy and Therapeutics (P&T) Process

Process to make clinically based recommendations that will help You access quality, low cost medicines within Your Benefit Program. The process includes healthcare 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 Prescription Drug List. 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.

### Pharmacy Benefits Manager (PBM)

A Pharmacy benefits management company that manages Pharmacy benefits on HealthKeepers' behalf. HealthKeepers' PBM has a nationwide network of Retail Pharmacies, a Home Delivery Pharmacy, and clinical services that include Prescription Drug List management.

HealthKeepers' PBM, in consultation with HealthKeepers, also provides services to promote and assist Members in the appropriate use of Pharmacy benefits, such as review for possible excessive use, proper dosage, Drug interactions or Drug/pregnancy concerns.

### Plan

The set of benefits, conditions, exclusions and limitations described in this document.

### Precertification

Please see the section "Requesting Approval for Benefits" for details.

### Premium

The monthly charge You must pay HealthKeepers to establish and maintain coverage under this Evidence of Coverage.

### Prescription Drug

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.

### Prescription Drug List

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 doctors and pharmacists has been reviewed for their quality and cost effectiveness. This Prescription Drug List 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 Prescription Drug List from time to time. A description of the Prescription Drugs that are listed is available upon request and at www.anthem.com.

### Prescription Order (Prescription)

A written request by a Provider, as permitted by law, for a Drug or medication and each authorized refill for same.

### Primary Care Physician (“PCP”)

A Network Provider who is a practitioner that specialized in family practice, general practice, internal medicine, pediatrics, geriatrics or any other Network Provider as allowed by Us. A PCP supervises, coordinates and provides initial care and basic medical services to a Member and is responsible for ongoing patient care.

### Provider

A professional or Facility licensed by law that gives healthcare services within the scope of that license. 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 Evidence of Coverage. If You have a question about a Provider not described in this Evidence of Coverage, please call the number on the back of Your Identification Card.

### Qualified Health Plan or QHP

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 (QHP Issuer)

A health plan insurance issuer that offers a QHP in accordance with the certification from an Exchange.

### Qualified Individual

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

A specific recommendation by a Member's PCP that the Member should receive evaluation or treatment from a specific Provider.

### Rehabilitative Services

Healthcare services that help a person get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in

a variety of Inpatient and/or Outpatient settings.

### Residential Treatment Center/Facility

A Provider licensed and operating as required by law, which includes:

1. Room, board and skilled nursing care (either an RN or LVN/LPN) available on-site at least eight hours daily with 24 hour availability.
2. A staff with one or more doctors available at all times.
3. Residential treatment that takes place in a structured facility-based setting, and does not take place outdoors, e.g., wilderness program or therapy.
4. The resources and programming to adequately diagnose, care and treat a psychiatric and/or substance use disorder.
5. A Facility that is designated residential, subacute or intermediate care and may occur in care systems that provide multiple levels of care.
6. A Facility that is fully accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO) or the Council on Accreditation (COA).

The term Residential Treatment Center/Facility 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. Wilderness therapy or programs

### Retail Pharmacy

An establishment licensed to dispense Prescription Drugs and other medications (other than Specialty Drugs) through a licensed pharmacist or Home Delivery Pharmacy service upon an authorized healthcare professional’s order.

### Self-Administered Drugs

Drugs that are administered, which do not require a medical professional to administer.

### Service Area

The counties of Accomack, Albemarle, Alleghany, Amelia, Amherst, Appomattox, Augusta, Bath, Bedford, Bland, Botetourt, Brunswick, Buchanan, Buckingham, Campbell, Caroline, Carroll, Charles City, Charlotte, Chesterfield, Clarke, Craig, Culpeper, Cumberland, Dickenson, Dinwiddie, Essex, Fairfax, Fauquier, Floyd, Fluvanna, Franklin, Frederick, Giles, Gloucester, Goochland, Grayson, Greene, Greensville, Halifax, Hanover, Henrico, Henry, Highland, Isle of Wight, James City, King and Queen, King George, King William, Lancaster, Lee, Loudoun, Louisa, Lunenburg, Madison, Mathews, Mecklenburg, Middlesex, Montgomery, Nelson, New Kent, Northampton, Northumberland, Nottoway, Orange, Page, Patrick, Pittsylvania, Powhatan, Prince Edward, Prince George, Prince William, Pulaski, Rappahannock, Richmond, Roanoke, Rockbridge, Rockingham, Russell, Scott, Shenandoah, Smyth, Southampton, Spotsylvania, Stafford, Surry, Sussex, Tazewell, Warren, Washington, Westmoreland, Wise, Wythe, and York. The cities of Bristol, Buena Vista, Charlottesville, Chesapeake, Colonial Heights, Covington, Danville, Emporia, Franklin, Fredericksburg, Galax, Hampton, Harrisonburg, Hopewell, Lexington, Lynchburg, Manassas, Manassas Park, Martinsville, Newport News, Norfolk, Norton, Petersburg, Poquoson, Portsmouth, Radford, Richmond, Roanoke, Salem, Staunton, Suffolk, Virginia

Beach, Waynesboro, Williamsburg, and Winchester.

Our plans are not available in the City of Fairfax, the Town of Vienna and the area east of State Route 123.

### Skilled Nursing Facility

A Facility operated alone or with a Hospital that cares for You after a Hospital stay when You have a condition that needs more care than You can get at home. It must be licensed by the appropriate agency and accredited by the Joint Commission or the Bureau of Hospitals of the American Osteopathic Association, or otherwise approved by Us. A Skilled Nursing Facility gives the following:

1. Inpatient care and treatment for people who are recovering from an illness or injury;
2. Care supervised by a doctor;
3. 24 hour per day nursing care supervised by a full-time registered nurse.

A Skilled Nursing Facility is not a place mainly for care of the aged, custodial care or domiciliary care; or a place for rest, educational, or similar services.

### Specialty Care Physician (Specialist or SCP)

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 healthcare.

### Specialty Drugs

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 through provider coordination and patient education. These drugs often require special handling, such as temperature controlled packaging and overnight delivery, and are often unavailable at Retail Pharmacies.

### Specialty Pharmacy

A Pharmacy that is designated by Us, other than a Retail Pharmacy or Home Delivery Pharmacy that provides high cost, biotech drugs which are used for the treatment of acute or chronic diseases.

### State

Each of the 50 States and the District of Columbia.

### Stay

The period from the admission to the date of discharge from a Facility, including Hospitals, hospices, and Skilled Nursing Facilities.

### Subscriber

The Member who applied for coverage and in whose name this Evidence of Coverage is issued.

### Tax Dependent

Tax Dependent has the same meaning as the term dependent under the Internal Revenue Code.

### Tax Filer

Tax Filer means 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.

### 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 entire amount the Provider charges.

### Urgent Care

Medical care for an unexpected illness or injury that cannot wait until a regularly scheduled office Visit. Urgent health situations are not life threatening and do not call for the use of an Emergency Room.

### Urgent Care Center

A licensed healthcare Facility that is separate from a Hospital and whose main purpose is giving immediate, short-term medical care, without an appointment, for Urgent Care.

### 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 doctor, would subject the patient to severe pain. Notwithstanding any provision of this Evidence of Coverage, 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.

### Utilization Review

A set of formal techniques designed to monitor the use of, or evaluate the necessity of, quality, effectiveness, or efficiency of medical or behavioral health services, Prescription Drugs (as set forth in the section Prescription Drugs Administered by a Medical Provider), procedures, and/or Facilities.

Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review.

### Visit

Is a period during which a Member meets with a Provider to receive Covered Services. 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 again both limits.

### We, Us and Our

HealthKeepers

### Year and Yearly

A 12 month period.

### You and Your

The Member, Subscriber and each covered Dependent.

# Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

## Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

### Spanish
Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

### Chinese
您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

### Vietnamese
Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

### Korean
귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

### Tagalog
May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

### Russian
Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

### Arabic
يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة.
(TTY/TDD: 711)

### Armenian
Դուք իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն՝ Ձեր ID քարտի վրա նշված համարով: (TTY/TDD: 711)

### Farsi
شما این حق را دارید که این اطلاعات و کمکها را به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به شماره مرکز خدمات اعضاء که بر روی کارت شناسایی‌تان درج شده است، تماس بگیرید. (TTY/TDD: 711)

French
Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. (TTY/TDD: 711)

Japanese
この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

Haitian
Ou gen dwa pou resevwa enfòmasyon sa a ak asistans nan lang ou pou gratis. Rele nimewo Manm Sèvis la ki sou kat idantifikasyon ou a pou jwenn èd. (TTY/TDD: 711)

Italian
Ha il diritto di ricevere queste informazioni ed eventuale assistenza nella sua lingua senza alcun costo aggiuntivo. Per assistenza, chiami il numero dedicato ai Servizi per i membri riportato sul suo libretto. (TTY/TDD: 711)

Polish
Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. (TTY/TDD: 711)

Punjabi
ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫ਼ਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸਰਵਿਸਿਜ਼ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Navajo
Bee ná ahoot'i' t'áá ni nizaad k'ehjí níká a'doowoł t'áá jíík'e. Naaltsoos bee atah nílínígíí bee néého'dólzingo nanitinígíí béésh bee hane'í bikáá' áaji' hodíílnih. (TTY/TDD: 711)

## It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.