Anthem

Ready to choose *your benefits?*

We can point you in the right direction.

ANTHEM HEALTHKEEPERS
Effective January 1, 2019

This guide is for information purposes only. You must enroll in a plan for your benefits to start.

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Let's take a look

We know picking a health plan is a big deal, so this guide makes it easier for you to understand your benefit options. We'll explain how the plans work and give you other important details. That way you can enroll with confidence!

In this guide, you'll find:

- How to use your health plan
- Health and wellness programs
- Your privacy and rights

Pay a visit to anthem.com to get an idea of what you can do once you're a member. Find a doctor, estimate care costs, sign up to get emails instead of mail and much more!

Using your health plan

It's easy to get started with your plan and make the best of your benefits.*

Choose a doctor in your plan

Avoid getting care from doctors outside of your plan; it will cost you more or your plan may not cover it at all. We've made it easy for you to find doctors in your plan. Visit **anthem.com** to look for a primary care doctor, hospitals, labs and other health care professionals in your plan.

Use your ID card

You'll be a member after you complete enrollment and your benefits begin. Then, you'll be able to use your ID card. Don't forget, it's always available and easy to use on the Anthem Anywhere mobile app. It's like your passport to care since you'll need to show it whenever you go to the doctor.

Anthem.com

Once your benefits begin and you access your ID card, register on **anthem.com** or on the Anthem Anywhere mobile app to get personalized information about your wellness programs and health plan.

- Find a doctor.
- Estimate your costs, before you step into the doctor's office.

Learn more at **anthem.com/guidedtour**.

Preventive care is covered at no extra cost

Preventive care from a doctor in your plan is covered at 100%. Getting these regular checkups, screenings and shots can help you stay healthy and catch problems early – when they're easier to treat. So, talk to your doctor about what preventive care you may need to protect your health.

Save emergency room visits for emergencies only

Knowing where to go for care saves you time and money. So if you have a real emergency, head straight to the ER or call 911. Otherwise, visit your regular doctor or an urgent care center for minor medical issues.

We're here for you

When you become a member, we make it easy for you to get your questions answered in the way that works best for you.

- **By phone:** Call the Member Services number on your mobile ID card.
- **Online:** Register at **anthem.com** or download the Anthem Anywhere mobile app to chat with a team member.

Done driving to the doctor? Hey there, Live Health Online!

You can visit a board-certified doctor 24/7 for simple things like the cold, flu, allergies and more with no appointments and no waiting room. All you need is the LiveHealth Online mobile app or a computer with a webcam to have a video visit with a doctor.** LiveHealth Online costs as little as an office visit or at most $49. Learn more at **livehealthonline.com.**

* Limitations and exclusions are listed in the back of this book.

**Prescription availability is defined by physician judgment and state regulations. LiveHealth Online is available in most states and is expected to expand in the near future. Visit livehealthonline.com to view the service map by state.

Health and wellness programs support you along the way

Your plan goes way beyond covering doctor visits

We can help you reach your health goals and save money on healthy products and services. After your benefits begin, you have easy access to these programs and tools on **anthem.com** or by calling the Member Services number on your mobile ID card.

24/7 NurseLine — Our registered nurses can answer your health questions wherever you are — any time, day or night. All you have to do is call.

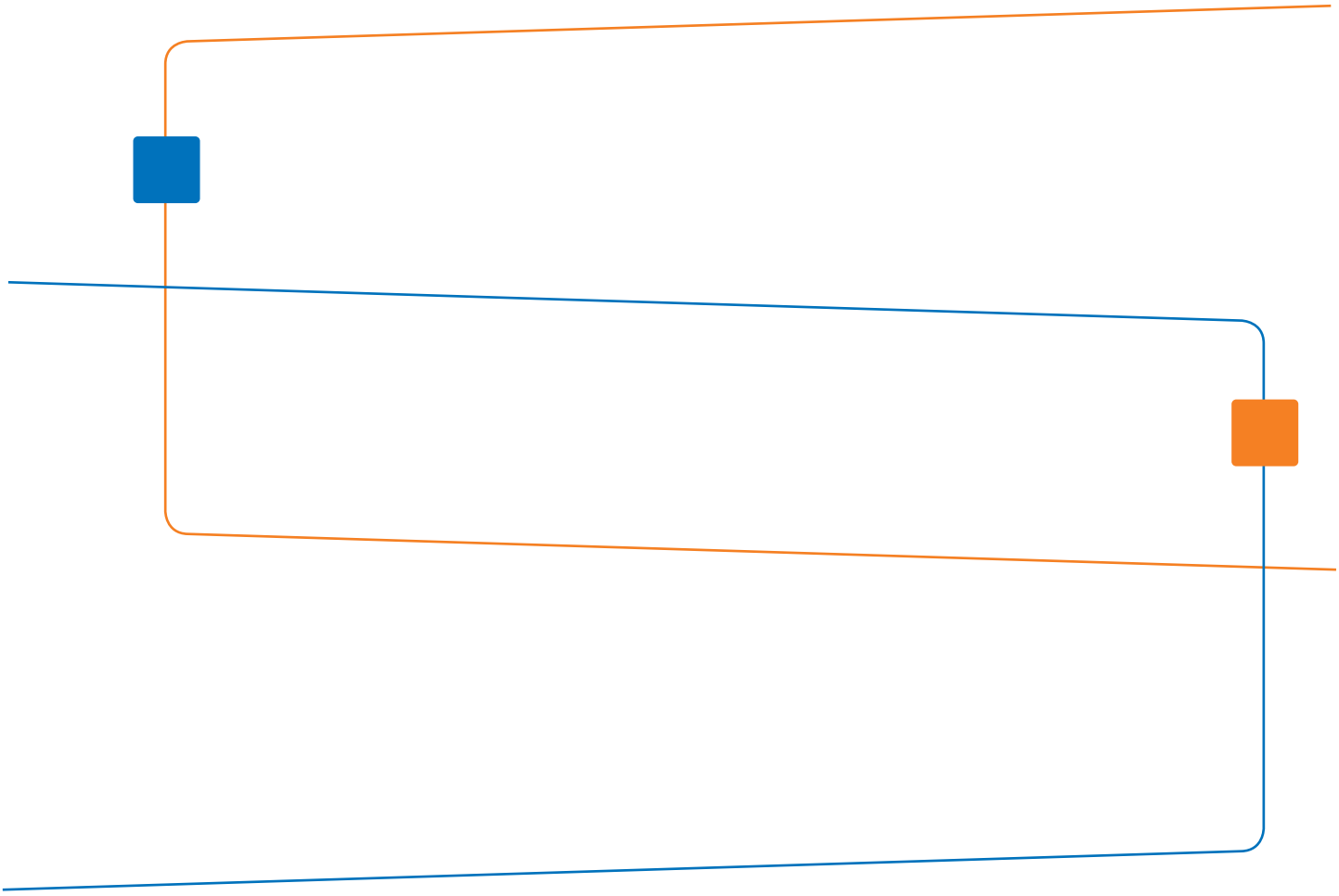
ConditionCare — Get support from a dedicated nurse team if you have asthma, diabetes, heart disease or heart failure. You work with dietitians, health educators and pharmacists to help you reach your goals and feel your best.

Future Moms — Moms-to-be get one-on-one support from registered nurses to help them have a healthy pregnancy, a safe delivery and a healthy baby.

LiveHealth Online — Using LiveHealth Online, you can have a video visit with a board-certified doctor or therapist on your smartphone, tablet or computer with a webcam. It's easy to use and there when you need it. All you have to do is sign up at **livehealthonline.com** or download the app.

Your plan details

In this next section, you'll find more information about your plan.



The ins and outs of coverage

Knowing that you have health care coverage that meets your and your family's needs is reassuring.

But part of your decision in choosing a plan also means you need to understand:

- Who can enroll
- How you and your employer handle coverage changes
- What's not covered by your plan
- How your coverage works with other health plans you might have

Who can be enrolled

You can choose coverage for just you. Or, you can have coverage for your family, including you and any of the following family members:

- Your spouse
- Your children age 26 or younger, including:
  - A newborn, natural child or a child placed with you for adoption
  - A stepchild
  - Any other child for whom you have legal guardianship

Coverage will end on the last day of the month in which they turn 26.

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

The ins and outs of coverage

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1. At the employer level, which affects you and other employees covered by an employer's plan, your plan can be:

Renewed	Canceled	Changed	When
●			Your employer: ○ Keeps its status as an employer. ○ Stays in our service area. ○ Meets our guidelines for employee participation and premium contribution. ○ Pays the required health care premiums. ○ Doesn't commit fraud or misrepresent itself.
	●		Your employer: ○ Makes a bad payment. ○ Voluntarily cancels coverage (30-days advance written notice required). ○ Is unable (after being given at least a 30-day notice) to meet eligibility requirements to maintain a group plan. ○ Still does not pay the required health care premium (after being given a 31-day grace period and at least a 15-day notice).
	●		○ We decide to no longer offer the specific plan chosen by your employer (you'll get a 90-day advance notice). ○ We decide to no longer offer any coverage in Virginia (you'll get a 180-day advance notice).
		●	You and your employer received a 30-day advance written notice that the coverage was being changed (services were added to your plan or the copays were lowered). Copays can be increased or services can be decreased only when it is time for your group to renew its coverage.

2. At the individual level, which affects you and covered family members, your plan can be:

Renewed	Canceled	When you
●		○ Stay eligible for your employer's coverage. ○ Pay your share of the monthly payment (premium) for coverage. ○ Don't commit fraud or misrepresent yourself.
	●	Give wrong information on purpose about yourself or your dependents when you enroll. Cancellation is effective immediately.
	●	○ Lose your eligibility for coverage. ○ Don't make required payments or make bad payments. ○ Commit fraud. ○ Are guilty of gross misbehavior. ○ Don't cooperate if we ask you to pay us back for benefits that were overpaid (coordination of benefits recoveries). ○ Let others use your ID card. ○ Use another member's ID card. ○ File false claims with us. Your coverage will be canceled after you receive a written notice from us.

The ins and outs of coverage

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Special enrollment periods

In most cases, you're only allowed to enroll in your employer's health plan during certain eligibility periods, such as when it's first offered to you as a "new hire" or during your employer's open enrollment period, when employees can make changes to their benefits for an upcoming year.

But there can be other times when you may be eligible to enroll. For example, let's say the first time you were offered coverage, you stated in writing that you didn't want to enroll yourself, your spouse or your covered dependents because you had coverage through another carrier or group health plan. If you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage) you may be able to enroll your family later. But you must ask to be enrolled within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Also, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Finally, a special enrollment period of 60 days will be allowed if:

- Your or your dependents' coverage under Medicaid or the State Children's Health Insurance Program (SCHIP) is terminated as a result of a loss of eligibility.
- You or your dependents become eligible for premium assistance under a state Medicaid or SCHIP plan.

To request special enrollment or get more information, contact your employer.

When you're covered by more than one plan

If you're covered by two different group health plans, one is considered primary and the other is considered secondary. The primary plan is the first to pay a claim and reimburse according to plan allowances. The secondary plan then reimburses, usually covering the remaining allowable costs.

The ins and outs of coverage

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Determining the primary and secondary plans

See the chart below to learn which health plan is considered the primary plan. The term "participant" means the person who signed up for coverage:

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

The ins and outs of coverage

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How benefits apply if you're eligible for Medicare

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

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

Recovering overpayments

If health care benefits are overpaid by mistake, we will ask for reimbursement for the overpayment. This is referred to as "coordination of benefits recoveries." We appreciate your help in the recovery process. We reserve the right to recover any overpayment from:

- Any person to or for whom the overpayments were made
- Any health care company
- Any other organization

The ins and outs of coverage

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What's not covered (exclusions)

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

Acupuncture

Authorization in advance

Your coverage does not include benefits for those selected services that require authorization in advance, when the advance authorization is not obtained.

Applied behavior treatment

Includes, but is not limited to, applied behavior analysis and intensive behavior interventions for all indications unless otherwise covered as law.

Biofeedback therapy

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

Certain prescription drugs

If you could use a **clinically equivalent drug**, unless required by law, certain prescription drugs aren't covered. "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 drug is considered as clinically equivalent, visit our website at **anthem.com**. If you or your doctor believe you need to use a different prescription drug, please have your doctor or pharmacist get in touch with us.

We'll cover the other prescription drug instead of the clinically equivalent drug only if we agree that it's medically necessary and appropriate. We will review benefits for the prescription drug from time to time to make sure the drug is still medically necessary.

Convenience items

Your coverage does not include benefits for over-the-counter convenience and hygienic items. This includes but is not limited to: adhesive removers, cleansers, underpads, diapers, and ice bags.

Complications

Your coverage does not include benefits for complications of or services related to noncovered services including services, supplies or treatment related to, or for problems directly related to, a service that's not covered by this plan.

Directly related means that the care took place as a direct result of the noncovered service and would not have taken place without the noncovered service.

Cosmetic services

Your coverage does not include benefits for, or related to **cosmetic services**, including treatments, services, prescription drugs, equipment or supplies given for cosmetic purposes. Cosmetic services are meant to preserve, change or improve how you look or are given for social reasons. No benefits are available for surgery or treatments to change the texture or look of your skin or to change the size, shape or look of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts).

This exclusion does not apply to surgery or procedures:

- To correct a deformity caused by disease, trauma or previous therapeutic process
- To correct congenital deformities that cause functional impairment
- On newborn children to correct congenital abnormalities

The ins and outs of coverage

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Delivery charges for delivering prescription drugs.

Dental or oral surgery services

Your coverage does not include benefits for the following **dental or oral surgery services**:

- Shortening or lengthening of the mandible or maxillae for cosmetic purposes.
- Surgical correction of malocclusion or mandibular retrognathia unless this condition creates significant functional impairment that cannot be corrected with orthodontic services.
- Dental appliances required to treat TMJ pain dysfunction syndrome or correct malocclusion or mandibular retrognathia.
- Medications to treat periodontal disease.
- Treatment of natural teeth due to diseases.
- Biting and chewing-related injuries, unless the chewing or biting results from a medical or mental condition.
- Restorative services and supplies necessary to promptly repair, remove or replace sound natural teeth.
- Extraction of either erupted or impacted wisdom teeth.
- Anesthesia and hospitalization for dental procedures and services except as specified as otherwise being covered.

This exclusion will not apply if your group's coverage includes a dental rider.

Drugs

Your coverage does not include drugs administered by a medical provider in the following circumstances:

- Drugs given to you or prescribed in a way that is against medical and professional standards of practice.
- Drugs which are over any quantity or age limits set by your coverage or by Anthem.
- 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 which are prescribed by a provider who does not have the necessary qualifications, registrations and/or certifications, as determined by us.
- 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.

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

Educational, vocational or self-management training purposes, except as otherwise specified as being covered or when received as part of covered preventive care.

Experimental/investigative procedures, as well as services related to or complications from such procedures except for clinical trial costs for cancer.

The ins and outs of coverage

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Family planning

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

Foot care

Services for palliative (to relieve pain and other symptoms) or cosmetic foot care:

- Flat foot conditions
- Support devices, arch supports, foot inserts, orthopedic and corrective shoes that are not part of a leg brace and fittings, castings and other services related to devices of the feet
- Foot orthotics, orthopedic shoes or footwear or support items unless used for a systemic illness affecting the lower limbs, such as severe diabetes
- Subluxations of the foot
- Corns, calluses and care of toenails (except in treatment for patients with diabetes or vascular disease)
- Bunions (except capsular or bone surgery)
- Fallen arches, weak feet or chronic foot strain
- Symptomatic complaints of the feet

Gene therapy as well as any drugs, procedures or health care services related to it that introduce or are related to introducing genetic material into a person intended to replace or correct faulty or missing genetic material.

Gynecomastia

Services for surgical treatments of gynecomastia for cosmetic purposes.

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

Hearing aids or exams to prescribe or fit hearing aids, unless otherwise listed as covered. This exclusion does not apply to cochlear implants.

Home care services:

- Homemaker services (except as rendered as part of hospice care)
- Maintenance therapy
- Food and home-delivered meals
- Custodial care and services

Hospital services:

- Guest meals, telephones, televisions and any other convenience items received as part of your inpatient stay
- Care by interns, residents, house doctors or other facility employees that are billed separately from the facility
- A private room, unless it is medically necessary and approved by us

Immunizations required for travel or work, unless such services are received as part of the covered preventive care services.

Lost or stolen drugs. Refills of lost or stolen drugs.

The ins and outs of coverage

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

These include but are not limited to:

- Exercise equipment; air conditioners, dehumidifiers, humidifiers and purifiers; hypoallergenic bed linens, bed boards; whirlpool baths; handrails, ramps, elevators and stair glides; telephones; adjustments made to a vehicle; foot orthotics; and changes made to a home or place of business.
- Replacement or repair of purchased or rental equipment because of misuse, abuse or loss or theft.
- Surgical supports, corsets or articles of clothing unless needed to recover from surgery or injury.
- Nonmedically necessary enhancements to standard equipment and devices.
- 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.

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

Services or supplies deemed not medically necessary as determined by us at our sole discretion. Except for this exclusion, all preventive care services and hospice care services described in the post-enrollment *Evidence of Coverage* or *Member Booklet* are covered.

This exclusion does not apply to services you receive on any day of inpatient care that we determined to be not medically necessary if such services are received from a professional provider who does not control whether you are treated on an inpatient basis or as an outpatient. This includes pathologists, radiologists, anesthesiologists or consulting doctors.

Also, this exclusion does not apply to inpatient services you receive from your admitting or attending doctor, other than inpatient evaluation and management services provided to you. Inpatient evaluation and management services include routine visits by your admitting or attending physician for purposes of reviewing patient status, test results and patient medical records. Inpatient evaluation and management visits do not include surgical, diagnostic or therapeutic services provided by your admitting or attending physician.

Also, this exclusion does not apply to the services you receive from pathologists, radiologists or anesthesiologists in an:

- Outpatient hospital setting
- Emergency room
- Ambulatory surgery setting

This exception does not apply if and when any such pathologist, radiologist or anesthesiologist assumes the role of attending physician. This will not prevent you from being able to appeal our decision that a service is not medically necessary.

Is a treatment considered experimental?

Many of our medical directors and staff actively participate in a number of national health care committees that review and recommend new experimental or investigative treatments for coverage.

To be approved for coverage, the service or product must have:

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

The ins and outs of coverage

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Non-emergency care except for the initial screening and stabilization of the patient. This includes but is not limited to suture removal in the emergency room.

Nutrition counseling and related services, except when provided as part of diabetes education, mental health treatment of an eating disorder or when received as part of a covered preventive care services visit or screening.

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

Obesity services and supplies related to weight loss or dietary control, including complications that directly result from such surgeries and/or procedures. This includes weight reduction therapies/activities, even if there is a related medical problem. Except for 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 a deformity after a previous therapeutic process involving gastric bypass surgery.

Off-label use, unless we must cover it by law or as we approve it.

Organ or tissue transplants, including complications caused by them, except as outlined in the *What is Covered* section of the post-enrollment *Evidence of Coverage* or *Member Booklet*.

Paternity testing, your coverage does not provide any benefits for paternity testing.

Prescription drugs received from a retail or home delivery (mail order) pharmacy

This exclusion does not apply to prescription medications for palliative care and pain management provided as part of hospice care services.

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, even if psychotherapy is included.
- Wilderness camps.

Rest cures, custodial, residential or domiciliary care and services

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

The ins and outs of coverage

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Routine physicals

Your coverage does not included benefits for routine physicals and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, sports programs or for other purposes, which are not required by law under preventive care benefits.

Services or supplies or devices:

- Not listed as covered under your health plan.
- Not prescribed, performed or directed by a provider licensed to do so.
- Received before the effective date or after a covered person's coverage ends.
- Received by providers not licensed by law to provide covered services. Examples include masseurs or masseuses (massage therapists), physical therapy technicians and athletic trainers.
- Services prescribed, ordered, referred by or received from a member of your immediate family, including your spouse, child, brother, sister, parent, in-law or self.
- Benefits for charges from stand-by physicians in the absence of covered services being rendered.
- Telephone consultations, charges for not keeping appointments or charges for completing claim forms.

Services or supplies if provided or available to a member:

- Under the Medicare program or under any similar program authorized by state or local laws or regulations or any future amendments to them. This exclusion does not apply to those laws or regulations which make the government program the secondary payer after benefits under this plan have been paid.
- Provided under a U.S. government program or a program for which the federal or state government pays all or part of the cost. This exclusion does not apply to health benefits plans for civilian employees or retired civilian employees of the federal or state government.
- This exclusion applies whether or not the member waives his or her rights under these laws, amendments, programs or terms of employment. However, we will provide the covered services specified in the post-enrollment *Evidence of Coverage* or *Member Booklet* when benefits under these programs have been exhausted.

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

- Amounts above the allowable charge for a service.
- Neurofeedback and related diagnostic tests.
- Penile implants.

Services or supplies to treat sexual dysfunction (male or female sexual problems). This includes medical and mental health services.

Skilled nursing facility stays:

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

Smoking cessation programs not affiliated with us.

Spinal manipulation

Your coverage does not include benefits for **spinal manipulation** or other manual medical interventions for an illness or injury other than musculoskeletal conditions.

Telemedicine

Noninteractive telemedicine services, including audio-only telephone, email messages, fax transmissions or online questionnaires.

The ins and outs of coverage

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Therapies:

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

Veins

Services for treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) when services are rendered for cosmetic purposes.

Vision services:

- Vision services or supplies, unless needed due to eye surgery and accidental injury.
- Services for radial keratotomy and other surgical procedures to correct refractive defects such as nearsightedness, farsightedness and/or astigmatism. This type of surgery includes keratoplasty and Lasik procedure.
- Services for vision training and orthoptics.
- Tests associated with the fitting of contact lenses, unless the contact lenses are needed due to eye surgery or to treat accidental injury.
- Sunglasses or safety glasses and accompanying frames of any type.
- Any nonprescription lenses, eyeglasses or contacts or Plano lenses or lenses that have no refractive power.
- Any lost or broken lenses or frames.
- Cosmetic lens options that are not otherwise specifically listed as covered.
- Any frame in which the manufacturer has imposed a no discount policy.
- Services needed for employment or given by a medical department, clinic or similar service provided or maintained by the employer or any government entity.
- Any other vision services not specifically listed as covered.
- For members through age 18, there is no benefit for frames or contact lenses purchased outside of our drug list (formulary).

Waived cost shares

Your coverage does not include waived cost shares when you receive services from a provider outside of your plan and this provider waives the copay, coinsurance or deductible usually required by this plan.

Weight-loss programs whether or not you join them under medical or physician supervision, unless specifically listed as covered. This exclusion includes, but is not limited to, commercial weight-loss programs (Weight Watchers®, Jenny Craig®, LA Weight Loss®, etc.) and fasting programs.

Work-related injuries or diseases

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

The ins and outs of coverage

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Besides the above exclusions, certain items are not covered under the prescription drug retail or home delivery (mail order) pharmacy benefit:

Prescription drug exclusions

- **Administration charges:** Charges for the administration of any drug except for covered immunizations as approved by us or the pharmacy benefits manager (PBM).
- **Charges not supported by medical records.** Charges for services not 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 any questions about whether a certain drug is covered and which drugs fall into this group, visit our website at **anthem.com**. If you or your doctor believes you need to use a different prescription drug, please have your doctor or pharmacist get in touch with us. We will cover the other prescription drug only if we agree that it is medically necessary and appropriate over the clinically equivalent drug. We will review benefits for the prescription drug from time to time to make sure the drug is still medically necessary.
- **Compound drugs:** Compound drugs unless all of the ingredients are FDA-approved as designated in the FDA's Orange Book: *Approved Drug Products with Therapeutic Equivalence Evaluations*, require a prescription to dispense and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer. Exceptions to non-FDA-approved compound ingredients may include multisource, nonproprietary vehicles and/or pharmaceutical adjuvants.
- **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 or 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 the doctor. This exclusion does not apply to drugs used with diagnostic services, drugs used during chemotherapy in the office, or drugs covered under the medical supplied benefit; those would be covered services.
- **Drugs not on the Anthem prescription drug list (a formulary):** You can get a copy of this list by calling us or visiting us at **anthem.com**. If you or your doctor believes you need a certain prescription drug not on the list, please refer to the *Prescription drug benefits at a retail or home delivery (mail order) pharmacy* section in your post-enrollment *Evidence of Coverage* or *Member Booklet* for details on requesting an exception.
- **Drugs over the quantity or age limits:** Drugs which are over any quantity or age limits set by your coverage or by us.
- **Drugs over the quantity prescribed or refills after one year:** Drugs in amounts over the quantity prescribed, or for a refill given more than one year after the date of the original prescription order.
- **Drugs prescribed by providers lacking qualifications, registrations or certifications.** Prescription drugs prescribed by a provider who does not have the necessary qualifications, registrations and/or certifications, as determined by us.
- **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.
- **Family members.** Services prescribed, ordered, referred by or given by a member of your immediate family, including your spouse, child, brother, sister, parent, in-law or self.

The ins and outs of coverage

(continued)

- **Gene therapy.** Gene therapy as well as any drugs, procedures and health care services related to it that introduce or are related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.
- **Infertility treatments:** Drugs used in assisted reproductive technology procedures to achieve conception (e.g., IVF, ZIFT, GIFT).
- **Items covered as durable medical equipment (DME):** Therapeutic DME, devices and supplies except peak-flow meters, spacers and blood glucose monitors. Items not covered under the prescription drugs at a retail pharmacy or home delivery (mail service) pharmacy benefit may be covered under the medical equipment (durable) or medical supplies benefit.
- **Items covered under the medical supplies and medications benefit:** Allergy desensitization products or allergy serum. While not covered under the prescription drugs at a retail pharmacy or home delivery (mail service) pharmacy benefit, these items may be covered under the medical supplies and medications benefit.
- **Lost or stolen drugs:** Refills of lost or stolen drugs.
- **Mail order providers other than our home delivery provider:** Prescription drugs dispensed by any home delivery provider other than our home delivery provider unless we must cover them by law.
- **Nonapproved drugs:** Drugs not approved by the FDA.
- **Nonmedically necessary services:** Services which we conclude are **not medically necessary**. This includes services that do not meet our medical policy, clinical coverage or benefit policy guidelines.
- **Nutritional or dietary supplements:** Nutritional and/or dietary supplements except those otherwise noted as being covered 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 from a licensed pharmacist.
- **Off-label use:** Unless we must cover the use by law or if we, or the pharmacy benefits manager, approve it.
- **Onychomycosis drugs:** Drugs for onchomycosis (toenail fungus), except when we allow it to treat members who are immuno-compromised or diabetic.
- **Over-the-counter items:** Drugs, devices and products, or prescription legend 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 legend drugs when any version or strength becomes available over the counter. This exclusion does not apply to over-the-counter products that we must cover under federal law with a prescription.
- **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. This exclusion does not apply to over-the-counter products that we must cover as a preventive care benefit under federal law with a prescription.

Let's talk about your privacy and rights

Safeguarding your information

As a member, you have the right to expect us to protect the privacy of your personal health information. We do this according to state and federal laws, and our policies. You also have certain rights and responsibilities when receiving your health care.

To learn more about how we protect your privacy, your rights and responsibilities when receiving health care and your rights under the Women's Health and Cancer Rights Act, go to **www.anthem.com/memberrights**. To ask for a printed copy, please contact your Benefits Administrator or Human Resources representative.

How we help manage your care

To decide if we'll cover a treatment, procedure or hospital stay, we use a process called Utilization Management (UM). Doctors and pharmacists who want to be sure you get the best treatments for certain health conditions make up Anthem's UM team. They review the information your doctor sends us. These reviews can be done before, during or after your treatment. We also use case managers. They're licensed health care professionals who work with you and your doctor to help you learn about and manage your health conditions. They also help you better understand your health benefits.

To learn more detailed information about how we help manage your care, visit **www.anthem.com/memberrights**.To request a printed copy, please contact your Benefits Administrator or Human Resources representative.

Notes

We've got your back!

Anthem

LiveHealth Online is the trade name of Health Management Corporation, a separate company, providing telehealth services on behalf of .

These policies have exclusions and limitations to benefits and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, please contact your insurance agent or contact us. The most detailed description of benefits, exclusions and restrictions can be found in the following publications which are issued upon initial enrollment or at renewal for Anthem HealthKeepers plans. If you have questions, please contact your agent, Group Administrator, or member services: Group Enrollment Agreement - HK-GEA (10/17), H-INTRO-HK (10/17), H-TOC (1/15), H-SB-POS (10/17), H-SB-LUM (10/17), HK-WORKS-HK (10/17), H-COVERED-HK (10/17), H-EXCL (10/17), H-CLAIMS-HK (10/17), H-ENR (10/17), H-COB (1/16), H-INFO-HK (1/17), H-RIGHTS (1/17), H-DEF-HK (10/17), H-EXH-A (1/17), H-INDEX (1/14), H-ENDS (1/17) Enrollment applications used for Anthem HealthKeepers: 490773 (10/17), 490773 (7/15) This is not a contract or policy. This brochure is not a contract with Anthem HealthKeepers offered by HealthKeepers, Inc. If there is any difference between this brochure and the Evidence of Coverage, Summaries of Benefits, and related Amendments, the provisions of the Evidence of Coverage, Summaries of Benefits and related Amendments will govern. For more information, please call Member Services at 800-421-1880. Member Services may also be contacted at PO Box 26623 Richmond, VA 23261-0031 Life and Disability products underwritten by Anthem Life Insurance. HealthKeepers, Inc. is an independent licensee of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

The Healthy Lifestyles programs are administered by Healthways, Inc., an independent company.