Anthem HealthKeepers

http://www.anthem.com
Customer service 1-855-580-1200

Anthem HealthKeepers
Offered by HealthKeepers, Inc.

2014

A Health Maintenance Organization with Point-of-Service

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 7 for details.

Serving: The Eastern portion of Virginia, see page 13 for a complete list of covered counties.

Enrollment in this Plan is limited. You must live or work in our geographic service area to enroll. See page 13 for requirements.

Enrollment codes for this Plan:

A91 Self Only
A92 Self and Family

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

RI 73-882

Important Notice from Anthem HealthKeepers About

Our Prescription Drug Coverage and Medicare

OPM has determined that the Anthem HealthKeepers prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. Thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefit coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15th through December 7th) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY 1-877-486-2048.

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Introduction

This brochure describes the benefits of the Anthem HealthKeepers Plan under our contract (CS 2943) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer service may be reached at 855-580-1200 or through our website: www.anthem.com. The address for Anthem HealthKeepers administrative offices is:

Anthem HealthKeepers
PO Box 27401
Richmond, VA 23279

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2014, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2014, and changes are summarized on page 14. Rates are shown at the end of this brochure.

Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

The ACA establishes a minimum value for the standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples:

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member, "we" means Anthem HealthKeepers.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB Plans' brochures have the same format and similar descriptions to help you compare plans.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care providers, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.

- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Periodically review your claim history for accuracy to ensure we have not been billed for services that you did not receive.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at 855-580-1200 and explain the situation.
  - If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

877-499-7295

Or go to www.opm.gov/oig

You can also write to:

United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise)
  - Your child age 26 or over (unless he/she was disabled and incapable of self-support prior to age 26)
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Preventing Medical Mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you ask questions and understand answers.

2. Keep and bring a list of all the medicines you take.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines and dosage that you take, including non-prescription (over-the-counter) medicines and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food and other allergies you have such as to latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask your pharmacist about the medication if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital is best for your health needs.

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
  - "Exactly what will you be doing?"
  - "About how long will it take?"
  - "What will happen after surgery?"
  - "How can I expect to feel during recovery?"
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

- www.ahrq.gov/consumer/. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org/. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Never Events

You will not be billed for inpatient services related to treatment of specific hospital acquired conditions or for inpatient services needed to correct never events, if you use Anthem HealthKeepers preferred providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

When you enter the hospital for treatment of one medical problem, you don't expect to leave with additional injuries, infections or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions.

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores and fractures; and reduce medical errors that should never happen called "Never Events". When a Never Event occurs neither your FEHB plan nor you will incur cost to correct the medical error.

FEHB Facts

Coverage Information

- **No pre-existing condition limitation**

We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

- **Minimum essential coverage (MEC)**

Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard**

The ACA establishes a minimum value for the standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.

- **Where you can get information about enrolling in the FEHB Program**

See www.opm.gov/healthcare-insurance for enrollment information as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies who participate in Employee Express
- A link to Employee Express
- Information on and links to other electronic enrollment systems

Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Benefits,* brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

- When you may change your enrollment
- How you can cover your family members
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire
- What happens when your enrollment ends
- When the next Open Season for enrollment begins

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact your employing or retirement office.

- **Types of coverage available for you and your family**

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately of any changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

If you have a qualifying life event (QLE) - such as marriage, divorce, or the birth of a child - outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/payroll office, or retirement office.

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below.

Children	**Coverage**
Natural, adopted children, and stepchildren	Natural, adopted children and stepchildren are covered until their 26th birthday.
Foster Children	Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.
Children Incapable of Self-Support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Married Children	Married children (but **NOT** their spouse or their own children) are covered until their 26th birthday.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

You can find additional information at www.opm.gov/healthcare-insurance.

Children's Equity Act

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;

- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children.

If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

When benefits and premiums start

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2014 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2013 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

When you retire

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

- **When FEHB coverage ends**

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment; or
- You are a family member no longer eligible for coverage.

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy).

- **Upon divorce**

If you are divorced from a Federal employee, or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM's Web site, www.opm.gov/healthcare-insurance/healthcare/plan-information/guides.

- **Temporary Continuation of Coverage (TCC)**

If you leave Federal service, Tribal employment, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal or Tribal job, if you are a covered dependent child and you turn 26, etc.

You may not elect TCC if you are fired from your Federal or Tribal job due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from www.opm.gov/healthcare-insurance. It explains what you have to do to enroll.

We also want to inform you that the Patient Protection and Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules.

- **Converting to individual coverage**

You may convert to a non-FEHB individual policy if:

- Your coverage under TCC or the spouse equity law ends (if you canceled your coverage or did not pay your premium, you cannot convert);
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal or Tribal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

- **Health Insurance Market Place**

If you would like to purchase health insurance through the Affordable Care Act’s Health Insurance Marketplace, please visit **www.HealthCare.gov**. This is a website provided by the U. S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

- **Getting a Certificate of Group Health Plan Coverage**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

For more information, get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC) under the FEHB Program*. See also the FEHB Web site at www.opm.gov/healthcare-insurance; refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and information about Federal and State agencies you can contact for more information.

Section 1. How this plan works

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These network providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from network providers, you will not have to submit claim forms or pay bills. You pay only the copayments, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-network providers, you may have to submit claim forms.

You should join an HMO because you prefer the Plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

We have Open Access benefits

Our Plan offers Open Access benefits. This means you can receive covered services from a participating provider without a required referral from you primary care physician or by another participating provider in the network.

We have Point of Service (POS) benefits

Our Plan offers Point-of-Service (POS) benefits. This means you can receive covered services from a non-participating provider. However, out-of-network benefits may have higher out-of-pocket-costs than our in-network benefits.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These network providers accept a negotiated payment from us, and you will only be responsible for your deductibles, copayments or coinsurance.

Preventive care services

Preventive care services are generally covered with no cost-sharing and are not subject to copayments, deductibles or annual limits when received from a network provider.

Annual deductible

The annual deductible must be met before benefits are paid for certain network or all non-network services.

Your Rights

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, and our providers. OPM's FEHB Web site (www.opm.gov/healthcare-insurance) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- HealthKeepers, Inc. has been in business since 1985.
- HealthKeepers is a for profit plan.

If you want more information about us, call (855) 580-1200, or write to Anthem HealthKeepers, PO Box 27401, Richmond, VA, 23279. You may also contact us by fax at (513) 872-3929 or visit our Web site at www.anthem.com.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Service Area

To enroll in this Plan, you must live in or work in our service area. This is where our providers practice. Our service area consists of the following counties in Virginia:

Accomack, Albemarle, Amelia, Brunswick, Buckingham, Caroline, Charles City, Chesapeake, Chesterfield, Clarke, Culpeper, Cumberland, Dinwiddie, Essex, Fairfax, Fauquier, Fluvanna, Frederick, Gloucester, Goochland, Greene, Greensville, Hanover, Henrico, Isle of Wight, James City, King and Queen, King George, King William, Lancaster, Loudoun, Louisa, Lunenburg, Madison, Mathews, Mecklenburg, Middlesex, New Kent, Northampton, Northumberland, Nottoway, Orange, Page, Powhatan, Prince Edward, Prince George, Prince William, Rappahannock, Richmond, Southampton, Spotsylvania, Stafford, Suffolk, Surry, Sussex, Virginia Beach, Warren, Westmoreland and York.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency or urgent care services. We will not pay for any other health care services out of our service area unless the services have prior plan approval.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. Changes for 2014

This is a new Plan for 2014. Please familiarize yourself with the benefits and limitations of the Plan.

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 855-580-1200 or write to us at Anthem HealthKeepers, PO Box 27401, Richmond, VA 23279 . You may also request replacement cards through our Web site at www.anthem.com.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments, deductibles and/or coinsurance. If you use our point-of-service program, you can also get care from non-Plan providers but it will cost you more. If you use our Open Access program you can receive covered services from a participating provider without a required referral from your primary care physician or by another participating provider in the network.

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.

We list Plan providers in the provider directory, which we update periodically. The list is also on our Web site.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our Web site.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member should choose a primary care physician.

- **Primary care**

Your primary care physician (PCP) can be a family practitioner, general practitioner, internist or pediatrician. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

Your PCP will provide your primary health care services such as annual physicals and medical tests, oversee care when you are ill or injured, and treat any chronic health problems or diseases. You should establish a personal and continuous relationship with your PCP. Building and maintaining this ongoing relationship is an important part of health care.

Your coverage does not require that you obtain a referral from your PCP to receive care from other network providers. However, you may want to let your PCP know about other network providers that are treating you so that your PCP can better oversee your health care.

If you want to change primary care physicians or if your primary care physician leaves the plan, call us. We will help you select a new one.

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care.

Here are some other things you should know about specialty care:

- If you are receiving care from a non-network provider and need to receive an extension of a previously approved course of treatment, you will be required to ask for the extension. You should request the extension at least 24 hours prior to the end of the authorized timeframe to avoid disruption of care or services. We will notify you of our coverage decision within 24 hours of your request.
- If you are seeing a specialist and your specialist leaves the Plan:

- You can contact your primary care physician who can help you locate another network provider; or
- You can continue to seeing the provider under the POS Non-network benefits of your plan

- If you have a chronic and disabling condition and lose access to your specialist because we:
  - terminate our contract with your specialist for other than cause;
  - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program plan; or
  - reduce our Service Area and you enroll in another FEHB plan;

you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

- **Hospital care**

Your Plan primary care physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

- **If you are hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our plan begins, call our customer service department immediately at 855-580-1200. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- you are discharged, not merely moved to an alternative care center;
- the day your benefits from your former plan run out; or
- the 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

You need prior plan approval for certain services

Network providers are required to obtain prior authorization in order for you to receive benefits for certain services. Prior authorization criteria will be based on multiple sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines.

- **Inpatient hospital admission**

Advance approval process - All non-emergency hospital admissions must be arranged by the member's admitting network physician and approved in advance by the plan, except for maternity admissions. We also reserve the right to determine whether the continuation of any hospital admission is medically necessary.

- **Other services**

Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain prior approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice. You must obtain prior authorization for certain services such as but not limited to:

- All inpatient admissions (except maternity)
- Newborn stays beyond the discharge of the mother
- Transplants (Human Organ and Bone Marrow/Stem Cell)

- Surgical treatment of morbid obesity
- Certain prescription drugs, such as; growth hormones
- Certain Durable medical equipment such as; power wheelchairs, standing frames or external insulin pumps
- Plastic/Reconstructive surgeries such as but not limited to: panniculectomy and abdominoplasty, non-routine oral surgery or vagus nerve stimulation
- Applied behavioral analysis
- Advanced Diagnostic Imaging such as; MRI, MRA, MRS, CT, CTA, PET, SPECT, Cardiac Echocardiogram, CT colonography and cardiac nuclear studies (such as cardiac stress test, MUGA)

How to request precertification for an admission or get prior authorization for Other services

First, your physician, your hospital, you, or your representative, must call us at 800-533-1120 before admission or services requiring prior authorization are rendered.

Next, provide the following information:

- enrollee's name and Plan identification number;
- patient's name, birth date, identification number and phone number;
- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting physician;
- name of hospital or facility; and
- number of planned days of confinement.

- **Non-urgent care claims**

For non-urgent care claims, we will then tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15 day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent care claims**

If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether it is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to provide notice of the specific information we need to complete our review of the claim. We will allow you up to 48 hours from the receipt of this notice to provide the necessary information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 855-580-1200. You may also call OPM's Health Insurance 2 at (202) 606-3818 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at (855) 580-1200. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

- **Emergency inpatient admission**

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.

- **Maternity care**

For childbirth admissions, prior approval is not required. If there is a complication and/or the mother and baby are not discharged at the same time, prior approval for an extended stay or for additional services is required

- **If your treatment needs to be extended**

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

What happens when you do not follow the precertification rules when using non-Plan providers

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

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below. For pre-service claims, we will respond in writing within 30 days after receipt of the request to appeal.

If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent care claim**

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to:

1. Precertify your hospital stay or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or

2. Ask you or your provider for more information.

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

3. Write to you and maintain our denial

- **To reconsider an urgent care claim**

In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Subject to a request for additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your costs for covered services

This is what you will pay out-of-pocket for covered care

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

Copayments

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive services.

Example: When you see an in-network Specialist you pay a copayment of $35 per office visit.

Deductible

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible.

- The calendar year deductible is $500 per person or $1,000 per family enrollment for covered in-network services. However, the calendar year deductible for covered non-network services is $1,000 per person or $2,000 per family enrollment.

Note: If you change plans during Open Season, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

If you change options in this Plan during the year, we will credit the amount of covered expenses already applied toward the deductible of your old option to the deductible of your new option.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance does not begin until you have met your calendar year deductible.

Example:

- You pay 20% of our allowance for durable medical equipment once your calendar year deductible is met for covered services received from in-network providers; or
- You pay 30% of our allowance for durable medical equipment once your calendar year deductible is met for covered services received from non-network providers.

Differences between our Plan allowance and the bill

When you receive covered services from non-network providers you are responsible for the difference between the actual charge and the Plan's maximum allowable amount and this amount will not apply toward your annual out-of -pocket maximum.

Your catastrophic protection out-of-pocket maximum

Network Services

After your network copayments and coinsurance total $1,900 per person or $5,500 per family enrollment for medical services in any calendar year, you do not have to pay any more for covered services. However, the copayments and/or coinsurance for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments and/or coinsurance for these services:

- Prescription drugs

All copayment or coinsurance amounts (if applicable) for first-tier, second-tier, third-tier or fourth-tier drugs purchased at both retail and mail service pharmacies will apply to the out-of-pocket expense limit for prescription drugs which is $3,500 per person per calendar year.

Non-network Services (POS)

After your deductible and coinsurance for POS benefits total $3,600 per person or $7,200 per family enrollment, for covered non-network services, you do not have to pay any further deductibles and/or coinsurance for covered POS services. However you may be responsible for paying the provider or facility any amounts by which their charges for services exceed our allowance. Also, the copayments and/or coinsurance for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments and/or coinsurance for these services:

- Prescription drugs

Be sure to keep accurate records of your copayments since you are responsible for informing us when you reach the maximum.

Carryover

If you changed to this Plan during open season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your old plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your old plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

Note: If you change options in this Plan during the year, we will credit the amount of covered expenses already accumulated toward the catastrophic out-of-pocket limit of your old option to the catastrophic protection limit of your new option.

When Government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Section 5. Benefits

See page 14 for how our benefits changed this year. Page 76 is a benefits summary of our high option. Make sure that you review the benefits that are available under the option in which you are enrolled.

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Section 5. Benefits Overview

The benefit package is described in Section 5. Make sure that you carefully review the benefits that are available.

Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the general exclusions in Section 6, they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about our benefits, contact us at 855-580-1200 or on our Web site at www.anthem.com.

When you seek care from within our network, we offer the following:

- No office visit copay for covered preventive care services
- No copay for primary care physician office visits
- $35 copay for specialist office visits
- $100 emergency room copay
- $200 per day copay up to a maximum of 3 days per covered inpatient hospital admission
- $150 outpatient facility copay for surgery

Section 5(a). Medical services and supplies provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- For network benefits to apply, Plan physicians must provide or arrange your care within the network.
- We will apply an annual deductible ($1,000 Self only or $2,000 Self and Family) and 30% coinsurance to covered POS services. Under POS, the annual catastrophic protection out-of-pocket maximum is $3,600 for Self only and $7,200 for Self and Family.
- Under the POS benefits, you are ultimately responsible for ensuring that your Non-Network provider obtains our prior-approval and/or precertification for certain services.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay
Diagnostic and treatment services	**High Option**
Professional services of physicians • In physician's office • Office medical consultations • Second surgical opinion	**Network**: $0 per PCP visit or $35 per Specialist visit **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance
• During a hospital stay • In a skilled nursing facility	**Network:** Nothing **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance
• In an urgent care center	$35 per visit
• At home	**Network:** $0 per PCP visit or $35 per Specialist visit **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance
Lab, X-ray and other diagnostic tests	**High Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine Mammograms • Ultrasound • Electrocardiogram and EEG	**Network:** Nothing **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance

Lab, X-ray and other diagnostic tests - continued on next page

Benefit Description	You pay
Lab, X-ray and other diagnostic tests (cont.)	**High Option**
• MRI's, MRA's, MRS's, CTA's, PET scans and CT scans	**Network:** Nothing **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance
Preventive care, adult	**High Option**
Full physical exams and periodic check-ups performed by your primary care physician and preventive screenings, such as: • Total Blood Cholesterol • Colorectal Cancer Screening, including - Fecal occult blood test - Sigmoidoscopy screening – every five years starting at age 50 - Colonoscopy screen—every ten years starting at age 50 And other diagnostic test as recommended by the America Cancer Society Guidelines • Chlamydia Screening • Routine Prostate Specific Antigen (PSA) test—one annually for men age 40 and older* • Routine Pap test—annual* • Osteoporosis screening • Abdominal Aortic Aneurysm screening—ultrasonography, one between the age of 65 and 75 for men with a history of smoking. • Screening for all adults for obesity and referrals for behavior change interventions for adults with a Body Mass Index (BMI) over 30kg/m2. • Over the counter items and services (ex. aspirin, vitamin D, etc.) when prescribed by your physician. ***Or more frequently if recommended by your HealthKeepers plan physician.**	**Network:** Nothing **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance
Well woman care; including, but not limited to: • Routine pap test • Human papillomavirus testing for women age 30 and up once every three years • Annual counseling for sexually transmitted infections • Annual counseling and screening for human immune-deficiency virus • Contraceptive methods and counseling • Screening and counseling for interpersonal and domestic violence • Annual screening and counseling for Human Immunodeficiency Virus (HIV) for sexually active women • Routine mammogram – once per calendar year or more frequently if recommended by a HealthKeepers physician	**Network**: Nothing **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC)	**Network**: Nothing

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	**High Option**
Note: A complete list of preventive care services recommended under the USPSTF is available online at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm. Additional resources available at HHS: www.healthcare.gov/prevention, IOM: http://www.iom.edu/Reports/2011/Early-Childhood-Obesity-Prevention-Policies/Recommendations.aspx AAP: http://www2.aap.org/immunization/pediatricians/pediatricians.html , CDC: http://www.cdc.gov/nccdphp/dnpao/hwi/resources/preventative_screening.htm.	**Network**: Nothing **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance
Not covered: • *Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp or travel.*	*All charges*
Preventive care, children	**High Option**
Well-child care charges for routine examinations, immunizations and care (up to age 22) • Examinations, such as: - Eye exams through age 17 to determine the need for vision correction - Hearing exams through age 17 to determine the need for hearing correction - Examinations done on the day of immunizations (up to age 22) • Childhood immunizations recommended by the American Academy of Pediatrics Note: A complete list of preventive care services recommended under the USPSTF is available online at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm. Additional resources available at HHS: www.healthcare.gov/prevention, IOM: http://www.iom.edu/Reports/2011/Early-Childhood-Obesity-Prevention-Policies/Recommendations.aspx AAP: http://www2.aap.org/immunization/pediatricians/pediatricians.html , CDC: http://www.cdc.gov/nccdphp/dnpao/hwi/resources/preventative_screening.htm.	**Network:** Nothing **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance
Not covered: • *Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp or travel*	*All charges*
Maternity care	**High Option**
Complete maternity (obstetrical) care, such as: • Prenatal care and Postnatal care • Delivery Note: Here are some things to keep in mind: You do not need to precertify your normal delivery; see page 16 for other circumstances, such as extended stays for you or your baby.	**Network:** Nothing **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance

Maternity care - continued on next page

Benefit Description	You pay
Maternity care (cont.)	**High Option**
You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	**Network:** Nothing **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance Note: You owe an inpatient hospital admission copay for network hospital services. The annual deductible and 30% coinsurance applies to non-network facilities under the POS benefits. See Section 5(c) *Services provided by a hospital or other facility, and ambulance services*
Breastfeeding support, supplies and counseling for each birth	**Network:** Nothing **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance
Family planning	**High Option**
Contraceptive counseling	**Network:** Nothing **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5 (b) • Surgically implanted contraceptives • Injectable contraceptive drugs • Intrauterine devices (IUDs) • Diaphragms Note: We cover oral contraceptives under the prescription drug benefit.	**Network:** $0 per PCP visit or $35 per Specialist visit **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance
Not covered: • *Reversal of voluntary surgical sterilization* • *Voluntary abortions and related care*	*All charges*
Infertility services	**High Option**
Diagnosis and treatment of infertility such as: • Artificial insemination: - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI)	**Network:** After satisfying the annual deductible, 50% of our allowance Coinsurance **POS Non-Network:** After satisfying the annual deductible, 50% of our allowance coinsurance
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* - *in vitro fertilization*	*All charges*

Infertility services - continued on next page

Benefit Description	You pay
Infertility services (cont.)	**High Option**
- *embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg* • *Fertility drugs*	*All charges*
Allergy care	**High Option**
• Testing and treatment • Allergy injections • Allergy serum	**Network:** $0 per PCP visit or $35 per Specialist visit **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance
Treatment therapies	**High Option**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on pages 37-40. • Respiratory and inhalation therapy • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, 90 visits per condition • Pulmonary rehabilitation	**Network:** $0 per PCP visit or $35 per Specialist visit **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance
• Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy	**Network:** $35 per calendar month copay **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance
Growth hormone therapy (GHT) Note: Growth hormones are covered under the prescription drug benefit. Please refer to Section 5(f). Note: We only cover GHT when we preauthorize the treatment.	See Section 5(f) for applicable copayment
Not covered: • *Therapy not listed as covered in this booklet*	*All charges*

Benefit Description	You pay
Physical and occupational therapies and cardiac rehabilitation	**High Option**
Up to a combined maximum of 30 visits per calendar year for rehabilitative and habilitative services of each of the following: • Qualified physical therapists and • Qualified occupational therapists Note: We only cover therapy when a provider: - orders the care Note: Services for autism do not apply toward this maximum/limit.	**Network:** $35 per Specialist visit **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*
Speech therapy	**High Option**
Up to a maximum of 30 visits per calendar year for rehabilitative and habilitative services of the following: • Speech therapists Note: Services for autism do not apply toward this maximum/limit.	**Network:** $35 per Specialist visit **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance
Hearing services (testing, treatment, and supplies)	**High Option**
Hearing screening for children through age 17 to determine the need for hearing correction (see *Preventive care, children)*	**Network:** $0 per PCP visit or $35 per Specialist visit **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance
Not covered: • *All other hearing testing and assistive devices* • *Hearing aids, testing and examinations for them*	*All charges*
Vision services (testing, treatment, and supplies)	**High Option**
One routine eye exam per calendar year Note: In order to receive network benefits you must utilize the Blue View Vision provider network. Note: See *Preventive care, children* for eye exams for children.	**Network:** $15 per visit at a participating Blue View Vision Network provider **POS Non-Network:** The difference between the $30 plan allowance and the provider's charge
We cover 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 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	**Network:** $0 per PCP visit or $35 per Specialist visit or 20% of our allowance coinsurance after satisfying the annual deductible for durable medical equipment. **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance

Vision services (testing, treatment, and supplies) - continued on next page

Benefit Description	You pay
Vision services (testing, treatment, and supplies) (cont.)	**High Option**
• 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 - corneal or scleral lenses are required to reduce a corneal irregularity other than astigmatism	**Network:** $0 per PCP visit or $35 per Specialist visit or 20% of our allowance coinsurance after satisfying the annual deductible for durable medical equipment. **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance
Not covered: • *Vision services or supplies unless needed due to eye surgery or 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 accompanying frames of any type;* • *Any non-prescription lenses, eyeglasses or contacts. Plano lenses or lenses that have no reflective power;* • *Any lost or broken lenses or frames;* • *Any blended lenses (no lines), oversize lenses, progressive multifocal lenses, photochromatic lenses, tinted lenses, coated lenses, cosmetic lenses or processes and UV-protected lenses;* • *Services needed for employment or given by a medical department, clinic, or similar service provided or maintained by the employer or any government entity; or* • *Any other vision services not specifically listed as covered.*	*All charges*
Foot care	**High Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	**Network:** $0 per PCP visit or $35 per Specialist visit **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance
Not covered: • *Flat foot conditions* • *Support devices, arch supports, foot inserts, orthopedic and corrective shoes that are not part of a leg* • *Brace and fittings, castings and other services related to devices of the feet* • *Foot orthotics* • *Subluxations of the foot*	*All charges*

Foot care - continued on next page

Benefit Description	You pay
Foot care (cont.)	**High Option**
• *Corns (except as treatment for patients with diabetes or vascular disease)* • *Bunions (except capsular or bone surgery)* • *Calluses (except as treatment for patients with diabetes or vascular disease)* • *Care of toenails (except as treatment for patients with diabetes or vascular disease)* • *Fallen arches* • *Weak feet* • *Chronic foot strain* • *Symptomatic complaints of the feet*	*All charges*
Orthopedic and prosthetic devices	**High Option**
• Artificial limbs and eyes • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers and surgically implanted breast implant following mastectomy. Note: Internal prosthetic devices are paid as hospital benefits; see Section 5 (c) for payment information. Insertion of the device is paid as surgery; see Section 5(b) for coverage of the surgery to insert the device. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.	**Network:** 20% of our allowance **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance
Not covered: • *Orthopedic and corrective shoes unless they are for diabetics with peripheral vascular disease* • *Arch supports* • *Foot orthotics*	*All charges*
Durable medical equipment (DME)	**High Option**
We cover rental (or purchase if that would be less expensive) of durable medical equipment. Also covered are maintenance and necessary repairs of medical equipment except when damage is due to neglect. Covered items include but are not limited to: • Hospital beds • Wheelchairs • Crutches • Walkers • Nebulizers • Traction equipment Note: Services received in-network and out-of-network accumulate toward this maximum/limit.	**Network:** After satisfying the annual deductible, 20% of our allowance coinsurance **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay
Durable medical equipment (DME) (cont.)	**High Option**
Not covered: • *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* • *repair or replacement of equipment you lose or damage through neglect*	*All charges*
Home health services	**High Option**
We cover treatment provided in your home on a part-time or intermittent basis when authorized by the Plan. Your coverage includes the following home health services: • visits by a licensed health care professional, including a nurse, therapist, or home health aide • physical, speech, and occupational therapy (services provided as part of home health are not subject to day-limits) Note: These services are only covered when your condition confines you to your home at all times except for brief absences.	**Network:** After satisfying the annual deductible, 20% of our allowance coinsurance **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance
Not covered: • *homemaker services (except as rendered as part of hospice care)* • *maintenance therapy* • *food and home delivered meals* • *custodial care and services*	*All charges*
Chiropractic	**High Option**
Spinal manipulation and manual medical therapy services • 30 visits per calendar year Note: Services must be received by a network provider. If you wish to receive care from a non-network provider, contact customer service at 855-580-1200 for authorization.	**Network:** $25 per visit to a network provider **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance
Not covered: • *any treatment or service not authorized by the Plan;* • *services for examination and/or treatment of strictly non-neuromusculoskeletal disorders, or conjunctive therapy not associated with spinal or joint adjustment;* • *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;*	*All charges*

Chiropractic - continued on next page

Benefit Description	You pay
Chiropractic (cont.)	**High Option**
• *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; or* • *vitamins, minerals, nutritional supplements, or any other similar type products*	*All charges*
Alternative treatments	**High Option**
No benefit	*All charges*
Educational classes and programs	**High Option**
• Diabetic self-management: outpatient training and education performed in-person, including medical nutrition therapy, when provided by a certified, licensed, or registered health care professional • Tobacco cessation programs	**Network:** Nothing **POS Non-Network:** After satisfying the annual deductible, nothing
Applied Behavior Analysis (ABA) services up to a $35,000 per year limit. Services included but limited to: • Diagnosis of autism spectrum disorder; • Treatment of autism spectrum disorder; • Psychiatric care; • Psychological care and • Therapeutic care	**Network:** 20% of our allowance coinsurance up to a $35,000 per year limit **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance up to a $35,000 per year limit

Section 5(b). Surgical and anesthesia services provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- For network benefits to apply, Plan physicians must provide or arrange your care within the network.
- We will apply an annual deductible ($1,000 Self only or $2,000 Self and Family) and 30% coinsurance to covered POS services. Under POS, the annual catastrophic protection out-of-pocket maximum is $3,600 for Self only and $7,200 for Self and Family.
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET ADVANCE APPROVAL FOR SOME SURGICAL PROCEDURES.** Please refer to the advance approval information shown in Section 3 to be sure which services require advance approval and identify which surgeries require advance approval. Under the POS benefits, you are ultimately responsible for ensuring that your non-network physician obtains our prior approval.

Benefit Description	You pay
Surgical procedures	**High Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Insertion of internal prosthetic devices . See 5(a) – *Orthopedic and prosthetic devices* for device coverage information • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	**Network:** Nothing, unless performed during an office visit, then the $0 per PCP visit or $35 per Specialist visit copay applies **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance
• Surgical treatment of morbid obesity (bariatric surgery)—eligible members must be age 18 or over and weigh at least 100 pounds over or twice the ideal weight for frame, age, height and gender who meet all the following criteria:	**Network:** Nothing, unless performed during an office visit, then the $0 per PCP visit or $35 per Specialist copay applies **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	**High Option**
- BMI of 40 or greater, or BMI of 35 or greater with an obesity-related co-morbid condition including, but not limited to: diabetes mellitus, cardiovascular disease, hypertension, or life threatening cardio-pulmonary problems (e.g., severe sleep apnea, Pickwickian syndrome, obesity related cardiomyopathy); and - must have actively participated in non-surgical methods of weight reduction; these efforts must be fully appraised by the physician requesting authorization for surgery; **and** - The physician requesting authorization for the surgery must confirm the following as part of the evaluation process: • The patient's psychiatric profile is such that the patient is able to understand, tolerate and comply with all phases of care and is committed to long-term follow-up requirements; and • The patient's post-operative expectations have been addressed; and • The patient has undergone a preoperative medical consultation and is felt to be an acceptable surgical candidate; and • The patient has undergone a preoperative mental health assessment and is felt to be an acceptable candidate; and • The patient has received a thorough explanation of the risks, benefits, and uncertainties of the procedure; and • The patient's treatment plan includes pre- and post-operative dietary evaluations and nutritional counseling; and • The patient's treatment plan includes counseling regarding exercise, psychological issues and the availability of supportive resources when needed.	**Network:** Nothing, unless performed during an office visit, then the $0 per PCP visit or $35 per Specialist copay applies **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care*	*All charges*
Reconstructive surgery	**High Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas;	**Network:** Nothing, unless performed during an office visit, then the $0 per PCP visit or $35 per Specialist copay applies **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance

Reconstructive surgery - continued on next page

Benefit Description	You pay
Reconstructive surgery (cont.)	**High Option**
- breast prostheses and surgical bras and replacements (see *Prosthetic devices*) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	**Network:** Nothing, unless performed during an office visit, then the $0 per PCP visit or $35 per Specialist copay applies **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges*
Oral and maxillofacial surgery	**High Option**
Oral surgical procedures, limited to: • surgical services on the hard or soft tissue in the mouth when the main purpose is not to treat or help • treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia; and • orthognathic surgery that is required because of a medical condition or injury which prevents normal function of the joint or bone and is deemed *medically necessary* to attain functional capacity of the affected part.	**Network:** Nothing, unless performed during an office visit, then the $0 per PCP visit or $35 per Specialist copay applies **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*
Organ/tissue transplants	**High Option**
These **solid organ transplants** are covered. Solid organ transplants are limited to: • Cornea • Heart • Heart/lung • Intestinal transplants - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Liver • Lung: single/bilateral/lobar • Pancreas	**Network:** Nothing **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
• Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis	**Network:** Nothing **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	**Network:** Nothing **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance
Blood or Marrow Stem Cell Transplants: Not subject to medical necessity. Plan's denial is limited to the cytogenetics, subtype or staging of the diagnosis (e.g. acute, chronic) as appropriate for the diagnosis Allogeneic transplants for: • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma with recurrence (relapsed) • Advanced non-Hodgkin's lymphoma with recurrence (relapsed) • Acute myeloid leukemia • Advanced Myeloproliferative Disorders (MPDs) • Amyloidosis • Chronic lymphocytic leukemia/small lymphocytic leukemia (CLL/SLL) • Hemoglobinopathy • Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) • Myelodysplasia/Myelodysplastic Syndromes • Paroxysmal Nocturnal Hemoglobinuria • Severe combined immunodeficiency • Severe or very severe aplastic anemia Autologous transplant for: • Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma recurrence (relapsed) • Advanced non-Hodgkin's lymphoma recurrence (relapsed) • Amyloidosis • Neuroblastoma	**Network:** Nothing **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance
Blood or Marrow Stem Cell Transplants: Not subject to medical necessity: Allogeneic transplant for:	**Network:** Nothing **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
• Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) Autologous transplants for: • Multiple myeloma • Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors	**Network:** Nothing **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance
Blood or Marrow Stem Cell Transplants: Not Subject to Medical Necessity. May Be Limited to Clinical Trials. Autologous transplants for: • Advanced Ewing sarcoma • Advanced Childhood kidney cancers • Aggressive non-Hodgkin's lymphomas (Mantle Cell lymphoma, adult T-cell leukemia/lymphoma, peripheral T-cell lymphomas and aggressive Dendritic Cell neoplasms) • Childhood rhabdomyosarcoma • Epithelial ovarian cancer • Mantle Cell (Non-Hodgkin lymphoma)	**Network:** Nothing **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance
Mini-transplants performed in a Clinical Trial Setting (non-myeloablative, reduced intensity conditioning for member over 60 years of age with a diagnosis listed under Section II): Subject to Medical Necessity	**Network:** Nothing **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance
Blood or Marrow Stem Cell Transplants under clinical trials. Allogeneic transplants for: • Sickle cell • Beta Thalassemia Major • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma Non-myeloablative allogeneic transplants for: • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma • Advanced non-Hodgkin's lymphoma • Chronic lymphocytic leukemia • Chronic lymphocytic leukemia/small lymphocytic leukemia (CLL/SLL) • Chronic myelogenous leukemia • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Myeloproliferative Disorders • Myeloproliferative/Myelodysplastic Syndromes	**Network:** Nothing **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
• Sickle Cell disease	**Network:** Nothing **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance
Blood or Marrow Stem Cell Transplants Allogeneic transplants for: • Infantile malignant osteopetrosis • Kostmann's syndrome • Leukocyte adhesion deficiencies • Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) • Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants) • Myeloproliferative disorders • Sickle cell anemia • X-linked lymphoproliferative syndrome Autologous transplants for: • Ependymoblastoma • Ewing's sarcoma • Medulloblastoma • Pineoblastoma • Waldenstrom's macroglobulinemia National Transplant Program (NTP) – We are a member of the Blue Distinction Center for Transplant.	**Network:** Nothing **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance
Donor testing for up to four bone marrow transplant donors from individuals unrelated to the patient in addition to testing of family members.	**Network:** Nothing **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor or as listed above* • *Implants of artificial organs* • *Transplants not listed as covered* • *Organ donation expenses unless this program is covering the organ transplantation.*	*All charges*

Benefit Description	You pay
Anesthesia	**High Option**
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center Note: We cover general anesthesia services for dental procedures only for: • Children under the age of 5 • Members who are severely disabled • Members who have a medical condition that requires admission to a hospital or outpatient surgery facility These services are only provided when it is determined by a licensed dentist, in consultation with the member's treating physician that such services are required to effectively and safely provide dental care. The dental procedures themselves are not covered.	**Network:** Nothing **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance
Professional services provided in – • Office	**Network:** $0 per PCP visit $35 per Specialist visit **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance

Section 5(c). Services provided by a hospital or other facility, and ambulance services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- For network benefits to apply, Plan physicians must arrange your care within the network.
- We will apply an annual deductible $1,000 Self only or $2,000 Self and Family and 30% coinsurance to covered POS services. Under POS, the annual catastrophic protection out-of-pocket maximum is $3,600 for Self only and $7,200 for Self and Family.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost-sharing works. Also, read Section 9 Coordinating benefits with Medicare and other coverage.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET ADVANCE APPROVAL FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require advance approval. Under the POS benefits, you are ultimately responsible for ensuring that we have approved your hospital admission.

Benefit Description	You pay
Inpatient hospital	**High Option**
Room and board, such as • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	**Network:** $200 per day up to a 3 day maximum per inpatient hospital admission **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood transfusions. This includes the cost of blood, blood products or blood processing • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services	**Network:** Nothing **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges*

Benefit Description	You pay
Outpatient hospital or ambulatory surgical center	**High Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays , and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma , if not donated or replaced • Pre-surgical testing • Dressings, casts , and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service • MRI's, MRA's, MRS's, CTA's, PET scans and CT scans Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	**Network:** $150 when a surgical procedure is performed, otherwise $35 per non-surgical visit **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance
Skilled nursing care facility benefits	**High Option**
Extended care/skilled nursing facility benefits up to 100 days per stay. Note: 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). Note: Services received in-plan and out-of-plan accumulate toward this maximum/limit.	**Network:** After satisfying the annual deductible, nothing **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance
Not covered: • *Custodial care* • *Treatment of psychiatric conditions and senile deterioration;* • *Facility services during a temporary leave of absence from the facility; or* • *A private room, unless it is medically necessary.*	*All charges*
Hospice care	**High Option**
Hospice care will be covered, for members diagnosed with a terminal illness with a life expectancy of six months or less. Covered services include the following: • Skilled nursing care, including IV therapy services; • Drugs and other outpatient prescription medications for palliative care and pain management; • Services of a medical social worker; • Services of a home health aide or homemaker; • Short-term inpatient care, including both respite care and procedures necessary for pain control and acute chronic symptom management. Respite care means non-acute inpatient care for the member in order to provide the member's primary caregiver a temporary break from care giving responsibilities. Respite care may be provided only on an intermittent, non-routine and occasional basis and may not be provided for more than five days every 90 days;	**Network:** Nothing **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance

Hospice care - continued on next page

Benefit Description	You pay
Hospice care (cont.)	**High Option**
• Physical, speech, or occupational therapy (services provided as part of hospice care are not subject to day-limits); • Durable medical equipment; • Routine medical supplies; • Routine lab services; • Counseling, including nutritional counseling with respect to the member's care and death; and • Bereavement counseling for immediate family members both before and after the member's death.	**Network:** Nothing **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance
Ambulance	**High Option**
Ambulance service when medically appropriate. Air ambulance services are also covered when pre-authorized or in cases of threatened loss of life.	**Network:** $50 copayment **POS Non-Network:** $50 copayment

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

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 lay person who possesses an average knowledge of health and medicine to result in:

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

What is urgent care?

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.

What to do in case of emergency:

Emergencies within our service area

If your condition is an emergency, you should be taken to the nearest appropriate medical facility.

The Plan 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 the Plan within 48 hours after you begin receiving care.

When you need care right away but it is not an emergency, you should always call a network physician first. The network physician may have you come into the office for an urgent appointment or refer you to an urgent care center for treatment. 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. Examples of urgent care situations include high fever, vomiting, sprains or minor cuts.

Emergencies outside our service area

If your condition is an emergency, you should be taken to the nearest appropriate medical facility.

The Plan 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 the Plan within 48 hours after you begin receiving care.

When you need care right away but it is not an emergency, you should always call a network physician first. The network physician may have you come into the office for an urgent appointment or refer you to an urgent care center for treatment. 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. Examples of urgent care situations include high fever, vomiting, sprains or minor cuts.

Benefit Description	You pay
Emergency inside or outside of our service area	**High Option**
• Emergency care at a doctor's office	$0 per PCP visit $35 per Specialist visit
• Emergency care at an urgent care center	$35 per visit
• Emergency care as an outpatient at a hospital, including doctors' services Note: We waive the ER copay if you are admitted to the hospital.	$100 per visit, if visit results in an inpatient admission you pay $200 per day to a 3 day maximum
Ambulance	**High Option**
Ambulance service when medically appropriate. Air ambulance services are also covered when pre-authorized or in cases of threatened loss of life.	**Network:** $50 copayment **POS Non-Network:** $50 copayment

Section 5(e). Mental health and substance abuse benefits

You must get advance approval in order to receive Plan benefits. Cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- For network benefits to apply, Plan physicians must provide or arrange your care within the network.
- Advance approval must be obtained if Non-Network providers are used.
- We will apply an annual deductible ($1,000 Self only or $2,000 Self and Family) and 30% coinsurance to covered POS services. Under POS, the annual catastrophic protection out-of-pocket maximum is $3,600 for Self only and $7,200 for Self and Family.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Benefit Description	You pay
Professional services	**High Option**
All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Outpatient and office Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers for the diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. • Outpatient and office Medication management • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits)	**Network:** Nothing **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance

Benefit Description	You pay
Diagnostics	**High Option**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	**Network:** Nothing **POS Non-Network:** Nothing
Inpatient hospital or other covered facility	**High Option**
Services provided by a hospital or substance abuse treatment facility	**Network:** $200 per day to a maximum of 3 days per inpatient hospital admission **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance
Outpatient hospital or other covered facility	**High Option**
Outpatient services provided and billed by a hospital or other covered facility • Services in approved treatment programs, such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment	**Network:** Nothing **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance
Not covered: • *Inpatient stays for environmental changes* • *Cognitive rehabilitation, educational or coma stimulation therapies* • *Vocational and recreational activities* • *Services for sexual deviation and dysfunction* • *Treatment of social maladjustment without signs of a psychiatric disorder* • *Remedial or special education services*	*All charges*

Section 5(f). Prescription drug benefits

Important things to keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on page 51.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Some prescription drugs are covered only if your physician obtains prior authorization from us. In addition, coverage for some drugs is provided in limited quantities.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 Coordinating benefits with Medicare and other coverage .

There are important features you should be aware of. These include.

- **Who can write your prescription.** A plan physician or licensed dentist must write the prescription, unless it is an emergency.
- **Where you can obtain them.** You must fill the prescription at a plan pharmacy, or by mail for certain maintenance medication. Most maintenance drugs are available through mail order. To find out if a certain maintenance drug is available by mail order call 1-866-281-4279. If you have a prescription filled at a non-participating pharmacy, you must complete and submit a claim to Anthem HealthKeepers's pharmacy network. Reimbursement will be based on what a participating pharmacy would have received had the prescription been filled at a participating pharmacy.
- **Using Participating Pharmacies.** We have an open formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. A prescription drug formulary is used to help your doctor make prescribing decisions. The fact that a drug is on this list doesn't guarantee that your doctor will prescribe you that drug. This list, which includes both generic and brand name drugs, is updated quarterly so that the list includes drugs that are safe and effective in the treatment of disease. Some drugs need to be approved - the doctor or drugstore will know which drugs they are. If you have a question regarding whether a particular drug is on our formulary drug list or requires prior authorization please call us at 1-855-580-1200.
- **These are the dispensing limitations.** Prescription drugs prescribed by a plan or referral doctor will be dispensed for up to a 30-day supply for a retail pharmacy and up to a 90-day supply through our mail order program. You must have used 75% of your prescription before it can be refilled. However, in the following circumstances, you can obtain an additional 30-day supply from your pharmacist:
  - you've lost your medication;
  - your medication was stolen; or
  - your physician increases the amount of your dosage
- **A generic equivalent will be dispensed if it is available**. Prescription drugs will always be dispensed as ordered by your physician. You may request, or your physician may order, the brand name drug. However, if a generic drug is available, you will be responsible for the difference in the allowable charge between the generic and brand name drug, in addition to your generic copayment.
- **Specialty medications.** Members who use certain covered specialty drugs must purchase them through Anthem HealthKeepers specialty pharmacy network. You may obtain a list of specialty drugs available through the specialty pharmacy by contacting Member Services or online at www.anthem.com. These specialty drugs will be covered only when obtained through this network. Specialty drugs are high-cost, injected, infused, oral or inhaled medications (including therapeutic biological products) that are used to treat chronic or complex illnesses or conditions. Specialty drugs may have special handling, storage and shipping requirements, such as temperature control. Specialty drugs may require nursing services or special programs to encourage patient compliance. The specialty pharmacy will fill both retail and mail order prescriptions, although the ability to provide a 90-day supply of a specialty drug may be limited by the storage requirements of that particular drug.

The specialty pharmacy provides dedicated patient care coordinators to help you manage your condition and toll-free twenty-four hour access to nurses and registered pharmacists to answer questions regarding your medications. You or your doctor can order your specialty medication direct from the specialty pharmacy by simply calling 1-800-870-6419. You will be assigned a patient care coordinator who will work with you and your physician to obtain prior authorization and to coordinate the shipping of your medication directly to you or your physician's office. Your patient care coordinator will also contact you directly when it is time to refill your prescription.

- **When you do have to file a claim.** Follow the same procedures for filing a prescription drug claim found on page 59.
- **Prior authorization.** We require prior review of selected formulary drugs as well as non-formulary drugs before payment is authorized; for example, growth hormones. Your doctor has a list of drugs that require special approval. You may obtain a copy of this list by simply contacting Member Services or from the Internet at www.anthem.com. This list is periodically modified. Your doctor or pharmacist should submit a request that includes the drug name, quantity per day and strength, period of time the drug is to be administered, medical condition for which the drug is being prescribed, the patient's name, ID number, date of birth, and relationship to the employee. The request may be submitted by telephone at 1-800-338-6180.

  The Plan cannot 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.
- **Half-Tablet Program**. This program will allow *members* to pay a reduced cost share on selected "once daily dosage" medications. The Half-Tablet Program allows *you* to obtain a 30-day supply (15 tablets) of the higher strength medication when written by the physician to take "½ tablet daily" of those medications on the approved list. The National Pharmacy and Therapeutics (P&T) Committee will determine additions and deletions to the approved list. The Half-Tablet Program is strictly voluntary and *your* decision to participate should follow consultation with and the concurrence of *your* physician. To obtain a list of the products available on this program contact 800-962-8192.

<table>
<tr><th>Benefit Description</th><th>You pay</th></tr>
<tr><td>Covered medications and supplies</td><td>High Option</td></tr>
<tr><td>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:
• Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as Not covered.
• Drugs that under state law are dispensed only with a written prescription from a physician or other lawful provider.
• Compound drugs
• Injectable insulin
• Syringes, needles, lancets, test strips and home glucose blood monitors
• Disposable needles and syringes for the administration of covered medications
• Off-label use of covered medication if prescribed for such use by a Plan doctor

Please note:
- Most prescriptions are limited to a 30-day supply for an original prescription or refill for up to one year.
- Some prescription drugs are covered only if your physician obtains prior authorization from us. In addition, coverage for some drugs is provided in limited quantities.
- Intravenous fluids and medication for home use are provided under home health services and some injectable drugs are covered under the Medical and Surgical Benefits.

Note: All deductible, copayment or coinsurance amounts (if applicable) for first-tier, second-tier, third-tier, or fourth-tier drugs purchased at both retail and mail service pharmacies will apply to the out-of-pocket expense limit for prescription drugs. See Section 4 Your catastrophic protections out-of-pocket maximum.
Note: Specialty drugs must be obtained through the Specialty Pharmacy Program.</td><td>Retail (up to a 30-day supply)
$0 Tier 1
$30 Tier 2
$50 Tier 3
Tier 4 - 20% of our allowance up to a maximum out-of-pocket of $200 per prescription order for a 30-day supply
Mail Order (up to a 90-day supply)
$0 Tier 1
$60 Tier 2
$100 Tier 3
Tier 1 drugs (lowest copay) – contains low cost or preferred medications. This tier may include generic, single source or multi-source brand drugs
Tier 2 drugs (middle level copay) – contains preferred medications that are moderate in cost. This tier may include generic, single source or multi-source brand drugs.
Tier 3 drugs (highest level copay) – contains non-preferred or high cost medications. This tier may include generic, single source or multi-source brand drugs.
Tier 4 drugs - Many drugs on this tier are "specialty" drugs used to treat complex, chronic conditions and may require special handling and/or management.</td></tr>
<tr><td>FDA approved drugs for the treatment of tobacco use.
Note: This includes prescription and over-the-counter medications.</td><td>Nothing</td></tr>
<tr><td>• Women's contraceptive drugs and devices
- The morning after pill when prescribed by a physician and purchased at a plan pharmacy.
• FDA approved prescription drugs and devices for birth control

Note: Over-the-counter contraceptive drugs and devices approved by the FDA require a written prescription by an approved provider.</td><td>Nothing</td></tr>
<tr><td>• Over the counter items and services (ex. aspirin, vitamin D, etc.) when prescribed by your physician</td><td>Nothing</td></tr>
</table>

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**High Option**
Not covered: • *Over-the-counter drugs;* • *Any per unit, per month quantity over the specified limit;* • *Drugs used mainly for cosmetic purposes;* • *Drugs that are experimental, investigational, or not approved by the FDA* • *Drugs for weight loss (except when authorized by the Plan doctor through the pre-determination process for treatment of morbid obesity);* • *Drugs not dispensed by a licensed pharmacy;* • *Drugs not prescribed by a licensed provider;* • *Any refill dispensed after one year from the date of the original prescription order;* • *Medicine covered by workers' compensation, Occupational Disease Law, state or government agencies;* • *Drugs obtained at a non-Plan pharmacy;* • *Medications used to treat sexual dysfunction;* • *Infertility medication; or* • *Medicine furnished by any other drug or medical service*	*All charges*

Section 5(g). Dental benefits

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We will apply an annual deductible ($1,000 Self only or $2,000 Self and Family) and 30% coinsurance to covered POS services. Under POS, the annual catastrophic protection out-of-pocket maximum is $3,600 for Self only and $7,200 for Self and Family.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You Pay
Accidental injury benefit	**High Option**
• Medically necessary dental services resulting from an accidental injury. You must submit a plan of treatment from your dentist or oral surgeon for prior approval by the Plan. For an injury that occurs on or after your effective date of coverage, you must seek treatment within 60 days after the injury; • The cost of dental services and dental appliances only when required to diagnose or treat an accidental injury to the teeth; • The repair of dental appliances damaged as a result of an accidental injury to the jaw, mouth or face	**Network:** $0 per PCP visit or $35 per Specialist visit **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance
Dental benefits	**High Option**
• Dental services to prepare the mouth for radiation therapy to treat head and neck cancer; or • Covered general anesthesia and hospitalization services for children under the age of 5, members who are severely disabled, and members who have a medical condition that requires admission to a hospital or outpatient surgery facility. These services are only provided when it is determined by a licensed dentist, in consultation with the member's treating physician that such services are required to effectively and safely provide dental care.	**Network:** $0 per PCP visit or $35 per Specialist visit **POS Non-Network:** After satisfying the annual deductible, 30% of our allowance coinsurance
Not covered: • *treatment of natural teeth due to accidental injury occurring on or after your effective date of coverage, unless treatment was sought within 60 days after the accidental injury and you submitted a treatment plan to the Plan for prior approval. No approval of a plan of treatment by the Plan is required for emergency treatment of a dental injury*	*All charges*

Dental benefits - continued on next page

Benefit Description	You Pay
Dental benefits (cont.)	**High Option**
• *restorative services and supplies necessary to promptly repair, remove, or replace sound natural teeth*	*All charges*

Section 5(h). Special features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
24/7 Nurse Line	Illness or injury can happen, no matter what time of day. As a Plan member you have access to a team of nurses, available to assist with your questions or concerns, 24 hours a day, seven days a week. These registered nurses can discuss symptoms you're experiencing, how to get the right care in the right setting and more, and you can call as often as you like. Call 800-337-4770.
Reciprocity	**BlueCard® Program** The BlueCard Program enables *you* to obtain Out-of-Area Covered Health Care Services, from a health care provider participating with a Host Blue, where available. The participating health care provider will automatically file a claim for the Out-of-Area Covered Health Care Services provided to *you,* so there are no claim forms for *you* to fill out. You will be responsible for the copayment amount, as stated in *this benefit brochure.* **Guest Membership Program**

	When *you* or any of *your* dependents will be staying temporarily outside of the *service area* for more than 90 days, *you* can request a guest membership to a Blue Cross and Blue Shield affiliated *HMO* in that area. An example of when this service may be utilized is when a dependent *student* attends a school outside of the *service area.* Call a Member Services representative at 1-855-580-1200 to make sure that the area in which *you* or *your* dependents are staying is within the Guest Membership Network. The Guest Membership Network is a network of Blue Cross and Blue Shield affiliated *HMO* Plans. If the area is within the network, *you* will need to complete a guest membership application and *you* will receive benefit/plan information as well as an ID card from the local Blue Cross and Blue Shield *HMO* affiliate where *you* or *your* covered dependents will be staying. Member Services will explain any limitations or restrictions to this benefit. If *you* are staying in an area that is not within the Guest Membership Network, this service will not be available.
Centers of Excellence	Blue Distinction is an innovative quality designation that helps consumers find medical facilities that have demonstrated expertise in select procedures. Blue Distinction recognizes facilities that meet objective, evidence-based thresholds for clinical quality, developed in collaboration with expert physicians and medical organizations. These designated facilities are subject to periodic reevaluation; reassessing their structure, processes and aggregate patient outcomes.

Non-FEHB benefits available to Plan Members

The benefits on this page are not part of the FEHB contract or premium, and you cannot file an FEHB disputed claim about them. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information contact the Plan at, (855) 580-1200 or visit their website at www.anthem.com.

Discount Programs

You can receive negotiated savings on selected health and wellness services and programs simply by being an eligible Anthem Blue Cross and Blue Shield HealthKeepers member. Services available through the SpecialOffers@Anthem program include but are not limited to:

Beltone - save up to 50% off all Beltone hearing aids and receive a free hearing screening.

HearPO - save up to 40% on all audiological services and testing.

TruVision - savings on LASIK procedures.

Prescription Glasses - save up to 30% on a complete pair of prescription glasses, most sunglasses and lens options at thousands of providers nationwide. Discounts available at certain retailers such as; LensCrafters, Target Optical, JCPenney Optical and most Pearle Vision locations.

Jenny Craig - receive a free 30-day program or receive 25% off a Premium Program.

GlobalFit - save at over 10,000 gyms nationwide.

livinglean - a breakthrough weight-loss program that succeeds where all other diets and programs fail. It teaches you step-by-step how to permanently eliminate your emotional cravings for foods that make you unhealthy.

livingeasy - a program that creates calm where there was fear, fulfilling relationships where there was anger, and clarity where there was overwhelm.

livingfree - stop smoking without feeling deprived, denied, or irritable.

livingsmart - teaches you how to modify or eliminate alcohol use.

Section 6. General exclusions – services, drugs, and supplies we do not cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition.** For information on obtaining prior approval for specific services, such as transplants, see Section 3 *When you need prior Plan approval for certain services.*

We do not cover the following:

- Care by non-plan providers except for authorized referrals or emergencies (see *Emergency services/accidents*).
- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services, drugs, or supplies not medically necessary.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice.
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants).
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies related to sex transformations.
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.
- Services, drugs, or supplies you receive without charge while in active military service.

Section 7. Filing a claim for covered services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, coinsurance, or deductible.

You will only need to file a claim when you receive emergency services from non-plan providers. Sometimes these providers bill us directly. Check with the provider.

If you need to file the claim, here is the process:

Medical and Hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, contact us at (855) 580-1200, or at our Web site at www.anthem.com.

When you must file a claim – such as for services you received outside the Plan's service area – submit it on the CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name, date of birth, address, phone number and ID number
- Name and address of the physician or facility that provided the service or supply
- Dates you received the services or supplies
- Diagnosis
- Type of each service or supply
- The charge for each service or supply
- A copy of the explanation of benefits, payments, or denial from any primary payor – such as the Medicare Summary Notice (MSN)
- Receipts, if you paid for your services

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

Submit your claims to:

Anthem HealthKeepers
P. O. Box 27401
Richmond, VA 23279

Prescription drugs

Submit your claims to:

Express Scripts
ATTN: Commercial Claims
P.O. Box 2872
Clinton, IA 52733-2872

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

Post-service claims procedures

We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.

Authorized Representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, we will permit a health care professional with knowledge of your medical condition to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Notice Requirements

If you live in a county where at least 10 percent of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes.

Section 8. The disputed claims process

You may be able to appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please visit www.anthem.com.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3 *If you disagree with our pre-service claim decision,* we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing Anthem HealthKeepers, PO Box 27401, Richmond, VA 23279, or calling 855-580-1200.

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/investigational), we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration decision will not afford deference to the initial decision and will be conducted by a plan representative who is neither the individual who made the initial decision that is the subject of the reconsideration, nor the subordinate of that individual.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: Grievances and Appeals, P.O. Box 27401, Richmond, VA 23279**;** and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: a) Pay the claim or b) Write to you and maintain our denial or.

	c) Ask you or your provider for more information You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
3	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance 2, 1900 E Street, NW, Washington, DC 20415-3620. Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call. • Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly. Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim. Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent. Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.
4	OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals. If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended. OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record. You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at (855) 580-1200. We will hasten our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 2 at (202) 606-3818 between 8 a.m. and 5 p.m. Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a dependent is covered under this plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Section 9. Coordinating benefits with Medicare and other coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit the NAIC web site at www.NAIC.org.

When we are the primary payor, we will pay the benefits described in this brochure.

When we are the secondary payor, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

TRICARE and CHAMPVA

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. IF TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

Workers' Compensation

We do not cover services that:

- You (or a covered family member) need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.

Medicaid

When you have this Plan and Medicaid, we pay first.

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, State, or Federal government agency directly or indirectly pays for them.

When others are responsible for injuries

If another person or entity, through an act or omission, causes you to suffer an injury or illness, and if we paid benefits for that injury or illness, you must agree to the provisions listed below. In addition, if you are injured and no other person or entity is responsible but you receive (or are entitled to) a recovery from another source, and if we paid benefits for that injury, you must agree to the following provisions:

- All recoveries you or your representatives obtain (whether by lawsuit, settlement, insurance or benefit program claims, or otherwise), no matter how described or designated, must be used to reimburse us in full for benefits we paid. Our share of any recovery extends only to the amount of benefits we have paid or will pay to you or your representatives. For purposes of this provision, "you" includes your covered dependents, and "your representatives" include, if applicable, your heirs, administrators, legal representatives, parents (if you are a minor), successors, or assignees. This is our right of recovery.
- We are entitled under our right of recovery to be reimbursed for our benefit payments even if you are not "made whole" for all of your damages in the recoveries that you receive. Our right of recovery is not subject to reduction for attorney's fees and costs under the "common fund" or any other doctrine.
- We will not reduce our share of any recovery unless, in the exercise of our discretion, we agree in writing to a reduction (1) because you do not receive the full amount of damages that you claimed or (2) because you had to pay attorneys' fees.
- You must cooperate in doing what is reasonably necessary to assist us with our right of recovery. You must not take any action that may prejudice our right of recovery.
- If you do not seek damages for your illness or injury, you must permit us to initiate recovery on your behalf (including the right to bring suit in your name). This is called subrogation.

If you do seek damages for your illness or injury, you must tell us promptly that you have made a claim against another party for a condition that we have paid or may pay benefits for, you must seek recovery of our benefit payments and liabilities, and you must tell us about any recoveries you obtain, whether in or out of court. We may seek a first priority lien on the proceeds of your claim in order to reimburse ourselves to the full amount of benefits we have paid or will pay.

We may request that you sign a reimbursement agreement and/or assign to us (1) your right to bring an action or (2) your right to the proceeds of a claim for your illness or injury. We may delay processing of your claims until you provide the signed reimbursement agreement and/or assignment, and we may enforce our right of recovery by offsetting future benefits.

Note: We will pay the costs of any covered services you receive that are in excess of any recoveries made.

Among the other situations covered by this provision, the circumstances in which we may subrogate or assert a right of recovery shall also include:

- When a third party injures you, for example, in an automobile accident or through medical malpractice;
- When you are injured on premises owned by a third party; or
- When you are injured and benefits are available to you or your dependent, under any law or under any type of insurance, including, but not limited to:
  - No-fault insurance and other insurance that pays without regard to fault, including personal injury protection benefits, regardless of any election made by you to treat those benefits as secondary to this Plan
  - Uninsured and underinsured motorist coverage
  - Workers' Compensation benefits

- Medical reimbursement coverage

Contact us if you need more information about subrogation.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical Trials

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy.
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care.
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials, this plan does not cover these costs.

When you have Medicare

What is Medicare?

Medicare is a health insurance program for:

- People 65 years of age or older
- Some people with disabilities under 65 years of age
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant)

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.

- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare's Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213, (TTY 1-800-325-0778) to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage.

It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage. If you do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10 % increase in premium for every 12 months you are not enrolled. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payor, we process the claim first.

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at (855) 580-1200 or see our Web site at www.anthem.com.

We do not waive any costs if the Original Medicare Plan is your primary payor.

- **Tell us about your Medicare coverage**

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country.

To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or at www.medicare.gov.

If you enroll in a Medicare Advantage plan, the following options are available to you:

This Plan and our Medicare Advantage plan: You may enroll in our Medicare Advantage plan and also remain enrolled in our FEHB plan. In this case, we do not waive any of our copayments or coinsurance for your FEHB coverage.

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓ *	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

Section 10. Definitions of terms we use in this brochure

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Clinical Trials Cost Categories

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs - costs for routine services such as doctor visits, lab test, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy.
- Extra care costs - costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care.
- Research costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See Section 4, page 20.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See Section 4, page 20.

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

Covered services

Care we provide benefits for, as described in this brochure.

Custodial care

Custodial care is care for your personal needs. This includes help in walking, bathing or dressing. It also includes preparing food or special diets, feeding, giving medicine which you usually do yourself or any other care for which the services of a professional health care provider are not needed.

Deductible

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits. See page 20.

Experimental or investigational services

Experimental/investigative means any service or supply that is judged to be experimental or investigative at the Plan’s sole discretion. Nothing in this exclusion shall prevent a member from appealing the Plan’s decision that a service is experimental/investigative. Services which do not meet each of the following criteria will be excluded from coverage as experimental/investigative:

1. Any supply or drug used must have received final approval to market by the U.S. Food and Drug Administration ("FDA") for the particular indication or application in question. Moreover, quantities of any drug or medication used must be within recommended maximum daily dose or duration established by the FDA or any of the standard reference compendia defined below. There are two exceptions which apply when a drug has received final approval to market by the FDA, but not for the particular indication or application in question.

a) 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; or

b) 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.

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.

2. There must be enough information in the peer-reviewed medical and scientific literature to let us judge the safety and efficacy.
3. The available scientific evidence must show a good effect on health outcomes outside a research setting.
4. 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.

Health care professional

A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

Medical necessity

Covered services 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.

Plan allowance

Our Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. In most cases, our Plan allowance is equal to a rate we negotiate with providers. This rate is normally lower than what they usually charge and any savings are passed on to you.

Post-service claims

Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.

Pre-service claims

Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.

Urgent care claims

A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum junction; or
- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent care claims usually involve Pre-service claims and not Post-service claims. We will judge whether a claim is an urgent care claim by applying the judgement of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at 855-580-1200. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Us/We

Us and We refers to Anthem HealthKeepers.

You

You refers to the enrollee and each covered family member.

Section 11. Other Federal Programs

Please note, the following programs are not part of your FEHB benefits. They are separate Federal programs that complement your FEHB benefits and can potentially reduce your annual out-of-pocket expenses. These programs are offered independent of the FEHB Program and require you to enroll separately with no government contribution.

Important information about three Federal programs that complement the FEHB Program

First, the **Federal Flexible Spending Account Program**, also known as FSAFEDS, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. Participating employees save an average of about 30% on products and services they routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)** provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under FEDVIP you may choose self only, self plus one, or self and family coverage for yourself and any eligible dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** can help cover long term care costs, which are not covered under the FEHB Program.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $250. The maximum annual election for a health care flexible spending account (HCFSA) or a limited expense health care spending account (LEX HCFSA) is $2,500 per person. The maximum annual election for a dependent care flexible spending account (DCFSA) is $5,000 per household.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible health care expenses (such as copayments, deductibles, insulin, products, physician prescribed over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
  FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.
- **Limited Expense Health Care FSA (LEX HCFSA)** – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your tax dependents including adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible **non-medical** day care expenses for your child(ren) under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.
- If you are a new or newly eligible employee you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1, you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?

Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS, (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern time. TTY: 1-800-952-0450.

The Federal Employees Dental and Vision Insurance Program - *FEDVIP*

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program. **This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment.**

FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.

Dental Insurance

All dental plans provide a comprehensive range of services, including:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with up to a 12-month waiting period. **Beginning in 2014, most FEDVIP dental plans cover adult orthodontia. Review your FEDVIP dental plan's brochure for information on this benefit.**

Vision Insurance

All vision plans provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Additional Information

You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/dental and www.opm.gov/vision. These sites also provide links to each plan's website, where you can view detailed information about benefits and preferred providers.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com . For those without access to a computer, call 1-877-888-3337, (TTY 1-877- 889-5680).

The Federal Long Term Care Insurance Program - *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment such as Alzheimer's disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives are eligible to apply. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more information, call 1-800-LTC-FEDS (1-800-582-3337), (TTY 1-800-843-3557), or visit www.ltcfeds.com.

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Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

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Summary of benefits for Anthem HealthKeepers - 2014

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions , limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- Under the POS benefits for non-network care, you must satisfy an annual deductible ($1,000 Self only or $2,000 Self and Family) and 30% coinsurance for all covered services.

Benefits	You Pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Network: $0 per office visit to your primary care physician or $35 per office visit to a specialist POS Non-network: After satisfying the annual deductible, 30% coinsurance	25
Services provided by a hospital:		
• Inpatient	$200 per day for a maximum of 3 days. POS Non-network: After satisfying the annual deductible, 30% coinsurance	42
• Outpatient	$150 per outpatient surgery admission or $35 per non-surgical admission POS Non-network: After satisfying the annual deductible, 30% coinsurance	43
Emergency visit to a hospital emergency room:		
• In-area or out-of-area	$100 per visit	46
Mental health and substance abuse treatment:		
• Inpatient	$200 per day for a maximum of 3 days POS Non-network: After satisfying the annual deductible, 30% coinsurance	48
• Outpatient	Regular cost-sharing	48
Prescription drugs:		
• **Retail pharmacy** - Up to a 30-day supply. Note: You must obtain specialty drugs from the Specialty Pharmacy Program unless we have granted a written exception.	$0 for Tier 1; $30 for Tier 2; $50 for Tier 3; 20% of our allowance up to a maximum out-of-pocket of $200 per prescription order for Tier 4.	51
• **Mail-order Program -** up to a 90-day supply	$0 for Tier 1; $60 for Tier 2; $100 for Tier 3	51
Dental care: We cover restorative services for accidental injury only and no other dental benefits.	Nothing	53

Benefits	You Pay	Page
Vision care: One routine eye exam per calendar year.	Network: $15 per visit at a participating Blue View Vision provider POS Non-Network: The difference between the $30 plan allowance and the provider's charge.	30
Special features: 24/7 Nurse Line		55
Protection against catastrophic costs: (your catastrophic protection out-of-pocket maximum)	Network: $1,900 Self Only or $5,500 Self and Family per year. POS Non-network: $3,600 Self only or $7,200 Self and Family per year. Prescription Drugs: $3,500 per person for Tier 4 drugs.	20

2014 Rate Information for Anthem HealthKeepers

Non-Postal rates apply to most non-Postal employees. If you are in a special enrollment category, refer to the Guide to Federal Benefits for that category or contact the agency that maintains your health benefits enrollment.

Postal rates apply to Postal Service employees. They are shown in special Guides published for APWU (including Material Distribution Center and Operating Services) NALC, NPMHU and NRLCA Career Postal Employees (see RI 70-2A); Information Technology/Accounting Services employees (see RI 70-2IT); Nurses (see RI 70-2N); Postal Service Inspectors and Office of Inspector General (OIG) law enforcement employees and Postal Career Executive Service employees (see RI 70-2IN); and non-career employees (see RI 70-8PS).

Postal Category 1 rates apply to career bargaining unit employees covered by the Postal Police contract.

Postal Category 2 rates apply to career non-bargaining unit, non-executive, non-law enforcement employees, and non-law enforcement Inspection Service and Forensics employees.

For further assistance, Postal Service employees should call:

Human Resources Shared Service Center
1-877-477-3273, option 5
TTY: 1-866-260-7507

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization who are not career postal employees. Refer to the applicable Guide to Federal Benefits.

Premiums for Tribal employees are shown under the monthly non-postal column. The amount shown under employee contribution is the maximum you will pay. Your Tribal employer may choose to contribute a higher portion of your premium. Please contact your Tribal Benefits Officer for exact rates.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share
High Option Self Only	A91	$196.68	$94.28	$426.14	$204.27	$72.42	$86.08
High Option Self and Family	A92	$437.62	$216.96	$948.18	$470.08	$168.34	$198.73