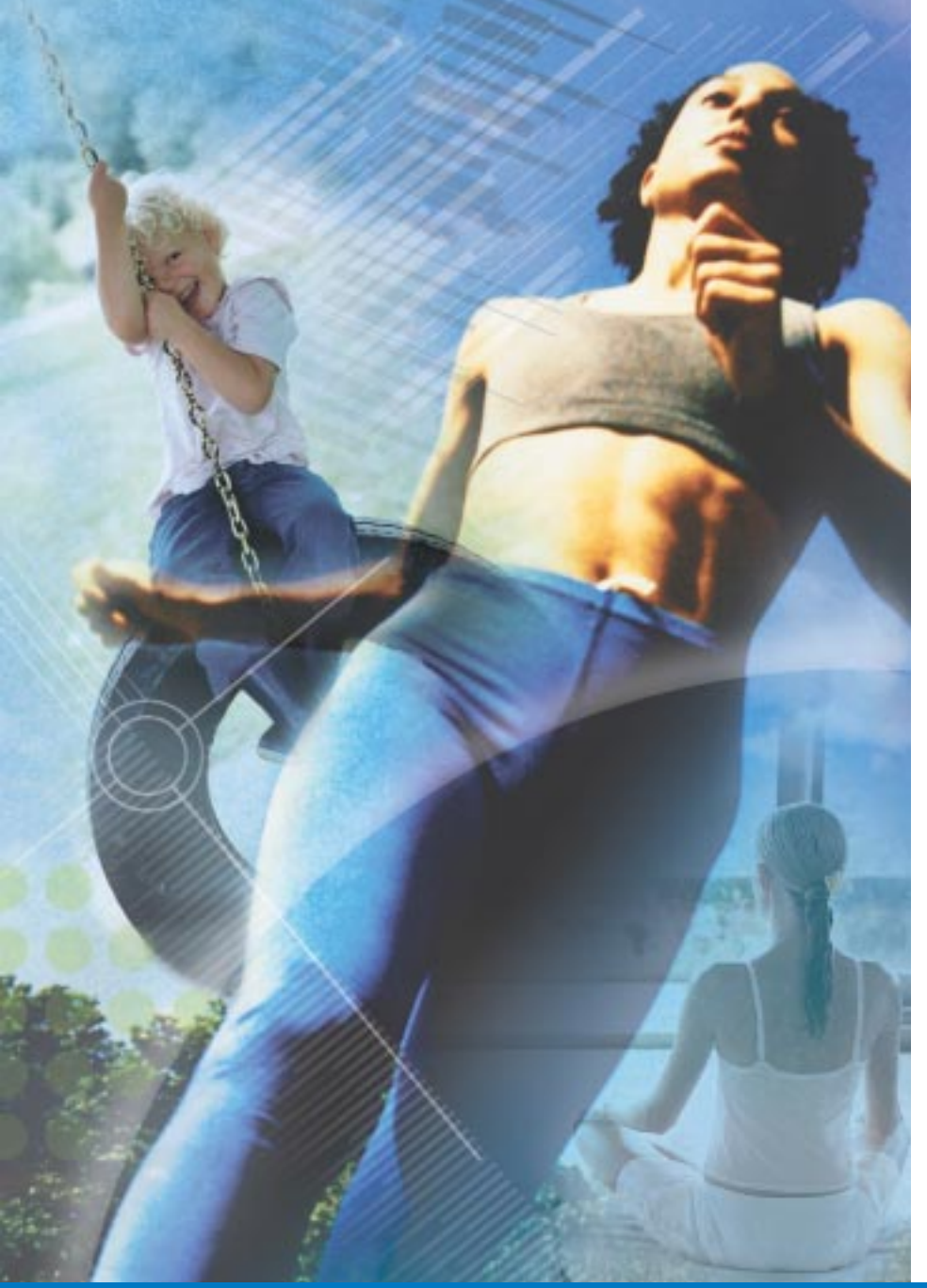


Anthem HealthKeepers
Offered by HealthKeepers, Inc.

Health and Wellness Resources

Your Benefits and Discount Services

The Ins and Outs of Coverage

Your Open Access Plan

anthem.com

Anthem HealthKeepers Open Access is offered by HealthKeepers, Inc., a health maintenance organization. Anthem HealthKeepers Open Access members have the right to privacy and that right is respected by all HealthKeepers, Inc. employees. We abide by the Commonwealth of Virginia Privacy Protection Act and have procedures in place to ensure your privacy. Any medical information we receive about Anthem HealthKeepers Open Access members, including medical records from health care professionals or hospitals, will be kept confidential and, except as permitted by law, will not be made available without the member's written permission. In a limited number of situations, HealthKeepers, Inc. may need to release confidential information without written authorization (but within the law) in order to administer benefits — for example, conducting coordination of benefits between health care carriers. Anthem HealthKeepers Open Access members can review any personal information collected about them by HealthKeepers, Inc. including medical records kept by us by calling Member Services. Corrections to inaccurate information will be made at their request.

The confidentiality of Anthem HealthKeepers Open Access members' medical records is not just protected by law; HealthKeepers, Inc. goes beyond the law's requirements to ensure privacy. All our employees are required to sign confidentiality statements keeping member records private, and by contract, members' employers are required to protect their records and are prohibited from misusing confidential information. HealthKeepers, Inc. also contractually requires network health care professionals to keep member medical records confidential. Any medical information received on our members' behalf is kept secure and access to this information is limited to approved employees.

HealthKeepers, Inc. operates as a managed care health insurance plan (also called an "MCHIP") subject to regulation in the Commonwealth of Virginia by both the State Corporation Commission Bureau of Insurance pursuant to Title 38.2 of the Virginia Code and the Virginia Department of Health pursuant to Title 32.1 of the Virginia Code.

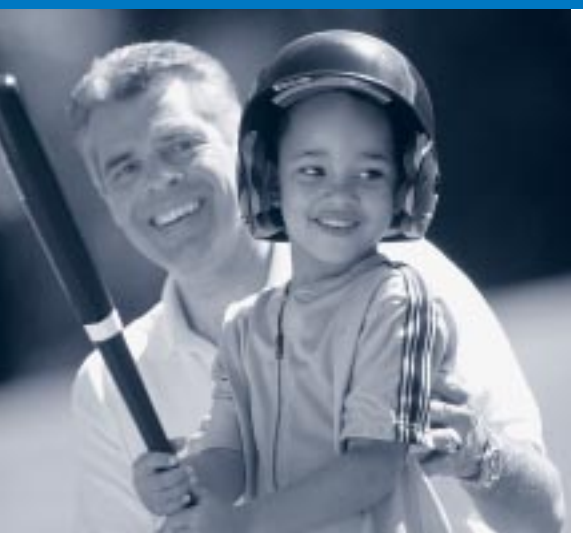
If an HMO Point of Service (POS) plan is not currently offered to you, a group health plan or benefit that allows you to access care from the provider of your choice whether or not the provider is a member of the HMO must be offered concurrently to all eligible employees when selecting HMO coverage. This coverage may be offered by this HMO or by another carrier.

Words you'll see

Throughout this brochure, the words "we," "us" and "our" are used. These words are referring to HealthKeepers, Inc.

The term "service area" means the geographical locations and boundaries where we are licensed to provide health care coverage. The cities and counties in the service area are listed in the HealthKeepers, Inc. provider directory.

Welcome to Anthem HealthKeepers Open Access



Do you have a plan for good health? With Anthem HealthKeepers Open Access, you do.

Your Anthem HealthKeepers Open Access plan gives you:

coverage for important health care services including:

- checkups and sick visits
- labs, x-rays and other types of tests
- specialist services with no referrals required
- emergency and urgent care
- annual routine eye exams
- maternity visits before and after having a baby
- care in a hospital

a team of doctors, nurses and other health care professionals who can:

- be there for you when you're sick
- help you make smart lifestyle choices to be in the best health you can
- take the time to listen to your concerns and answer your questions

access to discounts on:

- health and wellness products
- fitness centers and health clubs
- alternative medicine services
- vitamins, nutritional supplements and other health-related products
- eyewear and supplies
- laser vision correction surgery
- products and services that can help you become smoke free

Anthem HealthKeepers Open Access

One coordinating physician

Imagine having one doctor you could call — day or night — who could help you get the medical care you need. With your Anthem HealthKeepers Open Access plan, you have this one coordinating physician — someone who'll either treat you or assist you with getting you to the right specialist. This one doctor — your primary care physician — is there for you 24 hours a day and should be the first one you call when you need care.

You pick the doctor you want — any one of the Anthem HealthKeepers doctors specializing in family practice, general practice or internal medicine. For the young Anthem HealthKeepers Open Access members, pediatricians can be the care coordinators.

Having a primary care physician can make accessing health care services easy because:

- you can see one doctor for almost all your general health care needs
- you have someone who knows you and can help you see the right specialist
- you typically won't have to worry about claim forms or advance authorizations — your primary care physician takes care of it for you

Anthem HealthKeepers Open Access is a member of the Anthem HealthKeepers family of plans. Anthem HealthKeepers Open Access members may select any of the health care professionals in the Anthem HealthKeepers network. Plus, Anthem HealthKeepers Open Access members have access to the same special programs, features and discount services available to Anthem HealthKeepers members.

You can be assured that all the doctors in the Anthem HealthKeepers network meet strict standards for participation. And, you and your covered family members may each select a different primary care physician.

Primary care physician and specialist office visits

As an Anthem HealthKeepers Open Access member, you may visit a different primary care physician than the one you initially selected to oversee your care. This flexibility allows you to "try out" a new doctor's office when needed. To find another participating provider, just log on to www.anthem.com, check your Network Listing or call Member Services. Then, when calling to make your appointment, be sure to verify that the primary care physician is accepting new Anthem HealthKeepers Open Access patients. It's that easy! Plus, the amount you pay remains the same as the amount you would pay for an office visit to your regular primary care physician. To officially change your primary care physician and receive a new ID card, call Member Services.

Your coverage also allows you to see network specialists at any time you choose without a referral from your primary care physician. Keep in mind that while a referral isn't required, it is always a good idea to keep your primary care physician informed of your health issues because your primary care physician can be a great resource in helping you determine the type of specialist care that may best fit your needs. He or she can also handle advance authorizations for hospital stays and day surgery. Services rendered by specialists still need to meet our coverage and review guidelines and practices.

Emergency and urgent care services

Your Anthem HealthKeepers Open Access plan includes coverage for true emergency care services wherever you are located without a referral. You (or someone on your behalf) need to call the Anthem HealthKeepers 24-hour Nurse Advisor Line within 48 hours after receiving emergency care services that result in a hospital admission. Urgent care services are also covered without a referral.

Emergency care or urgent care…what's the difference?

A true emergency is the sudden onset of a medical condition with such severe symptoms that an average person with an average knowledge of health and medicine (also called a "prudent lay person") would seek medical care immediately because there may be:

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

If you ever need emergency medical care as described above, go immediately to the nearest medical facility. True emergency care is covered no matter where the services were received.

Urgent care conditions require prompt attention but usually do not require immediate procedures often associated with true emergency care. An urgent care situation is typically marked with persistent or unusual discomfort that can build rapidly and is associated with an illness or injury.

Reviews before you get care

Some services need to be authorized by us in advance to make sure they aren't being duplicated or causing you harm because of other medical care you're receiving. During these reviews, we will also make sure that the services are covered by your plan. The most common services being reviewed are for inpatient stays (in a hospital or skilled nursing facility) and these reviews often are called "prior authorizations."

Reviews after you get care

Sometimes situations happen so quickly that you don't have time to tell your primary care physician before you receive medical care. That's why you (or someone on your behalf) need to notify your primary care physician within 48 hours of receiving emergency care services that result in an admission. When this happens, the care you received will be reviewed by us to determine if it was a true emergency. This process is often called "retrospective review."

Anthem HealthKeepers Open Access deductible plans

If your plan includes a deductible requirement, covered services that are received during the last three months of the calendar year that are applied to your deductible may also be applied to the deductible required for the following year.

The difference between emergency and urgent care

Emergency care

- A prudent lay person thinks the condition needs immediate attention
- Could cause death or serious impairment

Urgent care

- The condition needs prompt attention
- Not life, limb or body system-threatening

Call the Anthem HealthKeepers 24-hour Nurse Advisor Line

If you don't know if your condition requires urgent care, you can call the toll-free Anthem HealthKeepers 24-hour Nurse Advisor Line. Available all day — every day — the nurses can help you determine what level of care your condition requires.

Example

A family of four is enrolled in a point-of-service plan with a $300 out-of-plan deductible. When one family member reaches the $300 amount for receiving care from a non-participating health care professional, out-of-plan benefits will begin for that member. Out-of-plan benefits for another family member will not begin until that family member has also reached the $300 out-of-plan calendar year deductible.

Keep in mind that professionals not in the network can charge whatever they want for covered services. If what they charge is more than the fee our network health care professionals have agreed to accept for the same service, the professionals not in our network may bill you for the difference between the two amounts.

In addition, when you visit non-participating health care professionals, you are responsible for obtaining prior authorization from us for all inpatient stays and outpatient mental health and substance abuse care or services will not be covered. Services received still need to meet our coverage and review guidelines and practices.

Point of Service members

If you have an Anthem HealthKeepers Open Access Point of Service plan, you have the option of visiting health care professionals outside of the network. This is called receiving "out-of-plan services." You and your covered family members must each first meet a calendar year deductible for most covered services before individual out-of-plan benefits begin. Once this dollar amount has been reached, when you or your covered family members receive services from professionals outside of the network, we will pay 70% of the amount doctors, hospitals and other health care professionals in our network have agreed to accept for the same covered services and you will pay the rest.

When you're admitted to the hospital or skilled nursing facility

Isn't it good to know that while you're a patient in the hospital or skilled nursing facility, you have an entire team working on your behalf? Made up of your doctor, the nurses and discharge planners at the hospital or skilled nursing facility and the Anthem HealthKeepers doctors and nurses on our staff, the Helping You Home®[1] team is working to make sure you get the right care in the right place at the right time.

Before you go to the hospital or skilled nursing facility…

Your team is involved in your care right from the start and they are the ones who discuss the need for you to be admitted to a hospital or skilled nursing facility (called "prior authorization"). With advances in technology, many medical procedures that once could only be done in a hospital can be done safely in a doctor's office or as day surgery in an outpatient setting.

While you're there…

Once you're admitted to a hospital or skilled nursing facility, the Helping You Home team focuses on the care you're receiving while you're an inpatient. The nurses and doctors make sure you're getting the right services for your condition, and just as important, make sure you're not going through unnecessary procedures. This phase is called "concurrent review" and tracks the progress you're making while you're still in the hospital or skilled nursing facility.

When you leave…

When it's time for you to leave the hospital or skilled nursing facility, the Helping You Home team will finalize the plan that will help you make a smooth transition back home. They can even help coordinate the services

you'll need at home, whether or not they are covered by your plan. Some of the factors considered by your team include:

- Do you need a specialized van to take you home or can a family member drive you?
- Do you need a hospital bed at home?
- Will you need home visits by a nurse?
- Do you need crutches, a walker or any other type of durable medical equipment?
- Will bandages need to be changed? Will you need a medical professional to do it? Can you change them yourself or teach a family member how to do it?

Health care coverage when you need it — at home or on the road

When you are home, it's easy to get medical care coordinated by your primary care physician. This feature of your Anthem HealthKeepers Open Access plan can make it just as easy to get the medical attention you need whether you are at home or away.

Short trips

Whether you travel for a living, or just take short trips away from the service area, you'll be covered for unexpected illnesses or injuries. You won't be covered for routine care, like immunizations or having a physical, when you're out of the service area because you can have these services before you leave or when you return.

Anthem HealthKeepers primary care physicians should be available by telephone 24 hours a day. Your primary care physician may partner with other primary care physicians to provide this "on-call" service so that when you need help after office hours, your primary care physician or the on-call primary care physician can be there for you. If you can't reach your primary care physician, you can call the Anthem HealthKeepers 24-hour Nurse Advisor Line.

When you'll be away for 90 days or more

For trips or a temporary relocation outside the service area of between 90 and 180 days, you and your covered family members can apply for the Guest Membership program. This special feature allows you to use the services of an affiliated Blue Cross and Blue Shield HMO plan in the area where you are staying. An Anthem HealthKeepers "Away From Home" coordinator will help you determine if you are eligible for a Guest Membership and will make the necessary arrangements for you to have coverage while away from home. The Guest Membership program can be extended on an indefinite basis for your covered dependents, such as children who attend school outside of Virginia.

Guest Memberships

Your Anthem HealthKeepers Open Access identification card carries the Cross and Shield — two symbols that are highly recognized by health care professionals. These symbols also link independent Blue Cross and Blue Shield plans across the country to provide coverage under the Guest Membership program — which is available in most states.

Anthem HealthKeepers Open Access

The Anthem HealthKeepers Family Health Program expands your wellness resources.

Expecting a baby?

Going to the doctor as soon as you suspect you're pregnant and continuing to get checkups and wellness visits throughout your pregnancy is the best way to start off your baby's life. Having good, reliable information about what to expect during the pregnancy and after the baby is born is important as well.

Baby Benefits, a prenatal program that accompanies your Anthem HealthKeepers Open Access plan, and is administered through our affiliated company, Health Management Corporation, involves your entire family with the pregnancy by providing information for the expectant mother, father and the rest of the family members. Your family will also be able to use the services of a specialized team of obstetric nurses, on-call for you 24 hours a day. These specially-trained nurses will work with you and your doctors to help prevent premature births and make sure the pregnancy is the healthiest possible. You'll also receive a congratulatory baby gift once your baby's born.

From the day your pregnancy test comes back positive, through the early years of your new child's life, your Anthem HealthKeepers Open Access plan gives you access to the support, information and coverage you need to make your experience a joyous, healthy event.

Living with asthma, diabetes, congestive heart failure or coronary artery disease?

Through Better Prepared℠ you can partner with specialized registered nurses who will answer any questions you have, give you information on the latest treatments available and work with your doctor to coordinate your health care services and resources. Learn ways to minimize the condition's effects and maximize health. Helpful articles, frequently asked questions, daily charts and diaries — helpful tools in managing these conditions — are available online at www.anthem.com. Better Prepared is administered through our affiliated company, Health Management Corporation.

Anthem HealthKeepers 24-hour Nurse Advisor Line

When you have questions about your health, give us a call. You have access to registered nurses who will take the time to listen to you, answer your questions and discuss your concerns. They're available 24 hours a day, every day — even holidays. Call as often as you'd like, that's what they are there for. And don't be surprised if you get a follow-up call from one of the nurses — knowing how you're doing is important to them. Anthem HealthKeepers 24-hour Nurse Advisor Line is administered through our affiliated company, Health Management Corporation.

Health and Wellness Resources

Visit us online

Anthem.com is your resource for the health care answers you need.

Member self-service

- Update your personal information or change your primary care physician.
- Determine the status of your claims or download them for your records.
- Use our secure message center to submit any questions you have about your coverage.
- Lost your ID card? Order a new one here.

Hospital quality comparison tool

- Discover how your hospital compares for procedures performed, complication rates and critical resources, such as intensive care units and the latest technology.

Treatment decision support tool

- Explore what you need to know to make the most informed decisions about your health — including the questions to ask your doctor, treatment options, community resources and issues to consider.

Answers@Anthem

- Search the provider directory for doctors, view the patient satisfaction scores they've received and even get driving directions to their office.
- Get up to speed on the prescriptions you take, their typical cost, alternative medications that may work just as well for less money out of your pocket, and information about interactions with other medicine you may be taking.

Plus…

- Use ***Cool Tools*** for interactive learning on everything from your child's adult height predictor to how much your smoking habit really costs you.
- Find help for that nagging backache through the ***Medical Library*** that covers over 2,500 topics.
- Feel like your treadmill's getting you nowhere? Check out the ***Fitness & Nutrition*** section to find an exercise plan that will help you meet your goals.
- Take advantage of member discounts on fitness clubs, weight loss programs, smoking cessation tools and phone support services, Anthem-recommended books on health and wellness, laser correction surgery and more through ***SpecialOffers@Anthem.***

Go to: Anthem.com ▶ Member ▶ Virginia

Need a doctor?

Look no further than the anthem.com provider network directory. Alongside the primary care doctors in our online directory you'll see how Anthem HealthKeepers members scored those doctors in our annual patient satisfaction survey. It's valuable information that can help you select a doctor that's right for you. (A score may not be avaliable if too few survey responses were received for a particular doctor.)

Access to wellness programs and discount services

Your Anthem HealthKeepers Open Access plan covers a wide range of benefits to help you be as healthy as possible. Living a healthy lifestyle and knowing how to make smart lifestyle choices can often improve health and are two of the reasons why your Anthem HealthKeepers Open Access plan gives you access to discount services in addition to health and wellness programs. The discount services described within this brochure and the Anthem HealthKeepers Family Health Program are not covered as benefits or guaranteed under your Anthem HealthKeepers Open Access plan and can be discontinued at any time.

Anthem HealthKeepers Open Access

Your Anthem HealthKeepers Open Access plan focuses on prevention and early detection of illnesses for members of all ages.

Coverage when you're feeling good...

You don't have to wait to be sick or injured before using your Anthem HealthKeepers Open Access plan. In fact, you have coverage for services that you can use when you're feeling fine. Your Anthem HealthKeepers Open Access coverage includes a wide range of wellness services in addition to preventive care and screenings:

- periodic checkups and well visits
- well baby visits, including recommended immunizations and tests
- an annual routine eye exam
- prenatal as well as postnatal care throughout pregnancy
- mammograms
- an annual gynecological exam for women (including a breast exam, pelvic exam and Pap test performed by any FDA-approved gynecological cytology screening technologies)
- prostate exams and an annual Prostate Specific Antigen test for men age 40 and older
- colorectal cancer screenings (barium enema, annual fecal occult blood test, sigmoidoscopy or colonoscopy)
- immunizations
- labs, x-rays and other screenings recommended by your primary care physician

...and when you're not

When you aren't feeling well or are injured — even if you think it's minor — you can count on your Anthem HealthKeepers Open Access coverage. Some of the services covered by your plan include:

- office visits to your primary care physician
- office visits to a specialist
- diagnostic tests, labs and x-rays
- physical, speech and occupational therapy
- inpatient stays in the hospital or skilled nursing facility
- surgery
- home health care services
- ambulance services
- medical equipment, supplies and appliances
- shots and injections

Healthy starts

Your Anthem HealthKeepers Open Access plan can help the youngest members of your family get off to the healthiest start possible. Coverage for well visits, immunizations and screenings is based on the recommendations of the American Academy of Pediatrics as well as those prescribed by Virginia's Commissioner of Health including:

Childhood Immunizations

DTP (Diphtheria, Tetanus, Pertussis)
Polio
HIB (Hemophilus Influenza B)
Hepatitis B
MMR (Measles, Mumps, Rubella)
Pneumococcal Conjugate
Varicella (Chicken Pox)

Childhood Screening Tests

Blood tests (HGB/HCT/FEP)
Urine tests
Tuberculin tests
Pure tone audiogram tests
Machine vision tests
Testing for congenital adrenal hyperplasia
Infant hearing screenings and other audiological exams

While these immunizations can lay a foundation for good health, some children will need special help during the first years of their lives. Children up to age 3 who are certified by the Department of Mental Health, Mental Retardation, and Substance Abuse Services (referred to as "DMH") as eligible under Part H of the Individuals with Disabilities Education Act are covered for early intervention services. These services are designed to help children reach or retain function so they are on a similar level with other children their age and include speech and language therapy, occupational therapy, physical therapy as well as assistive technology services and devices. These early intervention services are limited to a combined maximum of $5,000 and the amount you pay is determined by the service received.

Your benefits and discount services

- preventive care services, including checkups and screenings
- office visits (primary care physician and specialist)
- diagnostic services
- inpatient care
- emergency and urgent care
- discounts on alternative medicine services, health clubs, fitness centers as well as other health and wellness products

Plus–

While there are calendar year limits for certain services, you won't have to worry about reaching lifetime limits because Anthem HealthKeepers Open Access plans contain no lifetime benefit maximums.

Anthem HealthKeepers

Anthem HealthKeepers Open Access 15/20/1,000

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Care rendered in a health care professional's office:
You will typically pay a set fee as noted below.

Inpatient facility and most outpatient facility services:
- You will pay all of the costs associated with your care until you have paid **$1,000** in one calendar year.
- If two people are covered under your plan, each of you will pay the first $1,000 of the cost of your care ($2,000 total).
- If three or more people are covered under your plan, together you will pay the first $2,000 of your care. However, the most one family member will pay is $1,000.

After you reach this amount, known as your deductible,* you will pay 20% of the amount that health care professionals in our network have agreed to accept for their services when services are received at a hospital or facility. This deductible does not apply to outpatient facility services related to wellness.

** The deductible is the amount you are required to pay in a calendar year (January 1 to December 31) toward the cost of your care before coverage for certain benefits begins.*

Covered services	*You pay*
Checkups and sick visits during routine business hours (8:30 am – 5:00 pm, Monday through Friday, except holidays) • office visits • home visits • urgent care visits • in-office surgery • well baby visits • periodic checkup visits • prostate exams • immunizations • voluntary family planning	**$15** for each visit to your PCP **$20** for visits during non-routine business hours to your PCP **$35** for each visit to a specialist
Labs, diagnostic x-rays and other outpatient diagnostic tests during routine business hours (8:30 am – 5:00 pm, Monday through Friday, except holidays) • diagnostic x-rays • Prostate Specific Antigen (PSA) test • lab work • other diagnostic tests ** This fee is not required when these services are provided by the same professional on the same day as the office visit.*	**$15** for each visit to your PCP* **$20** for visits during non-routine business hours to your PCP* **$35** for each visit to a specialist* **20%** for each visit to a hospital or facility (after meeting deductible, except for services related to routine wellness)
• complex diagnostic imaging services to include: Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA) and Positron Emission Tomography (PET) scan ** Your payment responsibility is waived if services are billed as a part of an emergency room visit.*	**$100** for each visit*
Other outpatient services • home health care services • hospice services • insulin pumps and oxygen • durable medical equipment ($2,000 maximum) • ambulance travel	**No charge**
• dialysis* ** Only one payment is required for all dialysis treatments that occur within a calendar month.*	**$35** for each visit
• prosthetic devices • injectable medications* (excluding chemotherapy medications, allergy injections and serum dispensed in a physician's office) ** You will also pay an additional $15 or $35 office visit copayment depending on the type of provider who treats you.*	**20%** of the amount the health care professionals in our network have agreed to accept for their services
Therapy services • occupational** • physical** • speech** *** Visits are limited to 90 days (beginning with outpatient treatment) from the first day of treatment for a condition or illness.*	**$25** for each visit to a specialist's office **20%** for each visit to a hospital or facility (after meeting deductible)
• chemotherapy • radiation • intravenous • respiratory	**$35** for each visit to a specialist's office **20%** for each visit to a hospital or facility (after meeting deductible)

For the benefits listed with specific limits, all services received during the calendar year from January 1 to December 31 for that benefit are applied to that limit.

Covered services	You pay
Day surgery as an outpatient in a hospital or facility	**20%** for each visit to a hospital or facility (after meeting deductible, except for services related to routine wellness)
Inpatient stays in a hospital or facility • semi-private room • intensive or coronary care unit • private room when approved in advance • skilled nursing facility (limited to a 100 day maximum per illness or condition)	**20%** for each stay at a hospital or facility (after meeting deductible)
Routine annual gynecological exam • pelvic exam • breast exam • Pap test	**$15** for each visit to your PCP or a specialist
Mammograms • one baseline mammography screening for members age 35-39 • an annual mammogram for members age 40 and older or as often as deemed medically necessary	**$15** for each visit to your PCP **$35** for each visit to a specialist's office or facility **20%** for each visit to a hospital or facility (not subject to deductible)
Maternity • all routine pre-and postnatal care (excluding inpatient stays)	**$100** per pregnancy
• diagnostic tests • ultrasounds • non-stress tests and other fetal monitor procedures	**$35** for each visit to a specialist's office **20%** for each visit to a hospital or facility (after meeting deductible)
Outpatient mental health and substance abuse • medication management • individual therapy up to 30 minutes in length • group therapy	**$20** for each visit
• other mental health and substance abuse visits	**$30** for each visit
• partial day treatment programs	**20%** for each visit to a hospital or facility (not subject to deductible)
Routine vision • an annual routine eye exam	**$10** for each visit
• an annual contact lens fitting	**$25** for each visit
Plus valuable discounts on: eyewear and eyewear extras, laser vision correction surgery	
Emergency care and out of the service area urgent care • urgent care center visit • physician's office visit	**$35** for each visit
• true emergency care visits in or out of the service area * *waived if admitted directly to the hospital*	**20%** for each visit to an emergency room* (after meeting deductible)

Out-of-pocket maximums

What you will pay for covered services in one calendar year (January 1 — December 31)

If you are the only one covered by your plan, you will pay $3,000 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is $0, except for services listed below.

- If two people are covered under your plan, each of you will pay $3,000 ($6,000 total).
- If three or more people are covered under your plan, together you will pay $6,000. However, no family member will pay more than $3,000 toward the limit.

The following do not count toward the calendar year payment limit. You will still need to pay:

- the costs associated with vision benefits
- the cost of prescription drugs
- the cost of dental benefits
- the cost of chiropractic care
- the cost of care received when the benefit limits have been reached

This benefits overview insert is only one piece of your entire enrollment package. Exclusions and limitations are in the enrollment brochure.

Anthem HealthKeepers

Anthem HealthKeepers Open Access

Children are covered until December 31st of the year they turn 23

Now that you've read about the coverage an Anthem HealthKeepers Open Access plan offers — the benefits, wellness resources and discount services — it's also important that you take the time to read this section. It outlines who can enroll in your Anthem HealthKeepers Open Access plan, when and how your coverage can change, what's not covered by your plan and how your plan works with any other health care coverage you have.

Who you can cover

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

- your husband or wife
- the unmarried children you can claim as dependents, including children born to you, children you have adopted or are in the process of adopting, stepchildren or children for whom you are the legal guardian.

Some children have mental or physical challenges that prevent them from living independently. The dependent age limit does not apply to these enrolled children as long as these challenges were present before they reached age 23.

How and when your coverage can be changed

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

Ins and Outs of Coverage

1. On the employer level — which impacts you as well as all employees under your employer's plan — your Anthem HealthKeepers Open Access plan can be…

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

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

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

Anthem HealthKeepers Open Access

Have you had health care coverage before? Are you covered by a health care plan now?

When you first enroll in Anthem HealthKeepers Open Access

(This information applies only to those members whose employer has between two and 50 employees.)

Have you been treated for or diagnosed as having a specific condition other than pregnancy? If you have been, did the diagnosis or treatment occur less than 6 months before the date you will begin coverage under your employer's Anthem HealthKeepers Open Access plan? If so, there is a 12-month period when services will not be covered for those specific conditions — often called "pre-existing conditions." All other covered services not related to the pre-existing conditions will be available from your first day as a Anthem HealthKeepers Open Access member.

If you or a covered family member have had breast cancer and have been free of the disease for at least five years, it is not considered a pre-existing condition.

Your 12-month waiting period can be reduced by the number of months of "creditable coverage" you have before your Anthem HealthKeepers Open Access coverage starts. Creditable coverage is earned by having coverage under most types of group or individual:

- health insurance programs,
- HMO plans,
- health service plans,
- individual health insurance coverage,
- health plans offered under Chapter 89 of Title 5, United States Code,
- fraternal society plans, or
- publicly-sponsored plans like Medicare, Medicaid or TRICARE.

You should receive verification of this coverage (called a "certificate of creditable coverage") from either the employer with whom you had the coverage or the health care company that provided it. Call Member Services if you'd like us to help you obtain your certificate of coverage. If you go more than 63 days without health care coverage, your past health care coverage is not considered creditable coverage.

Ins and Outs of Coverage

The chart below shows the effect creditable coverage can have on the 12-month waiting period.

No waiting period	Reduction in the 12-month waiting period	when…
✓		your employer is switching your coverage to Anthem HealthKeepers Open Access and you and your covered family members have all been enrolled under your employer's previous health care plan.
✓		an infant, within 31 days of birth, has been covered under a group or individual insurance or HMO plan, service plan, fraternal plan or a publicly-sponsored plan like Medicare, Medicaid or TRICARE or similar plan as described in the member booklet.
✓		children you have adopted or are going to adopt are under the age of 18 and • have been covered under a group insurance or HMO plan, a government plan (Medicare, Medicaid, TRICARE or other similar publicly-sponsored program) or similar plan as described in the member booklet within 31 days of the adoption or placement and did not go more than 63 days without coverage, and • will be enrolled in your Anthem HealthKeepers Open Access coverage within 31 days of their initial eligibility. Otherwise, they may not be eligible to enroll in your plan for up to one year.
	✓	you have just joined an employer who has been offering Anthem HealthKeepers Open Access coverage and you were covered by another health plan before enrolling in your new employer's Anthem HealthKeepers Open Access plan. Often the waiting period will be reduced by the number of months you were covered under your former employer's plan.

Factors used to set the price of health care coverage for employers with 2 to 99 employees

- the Anthem HealthKeepers Open Access plan selected by your employer
- your employer's location
- the age of each employee
- the number of enrolled employees
- the number of dependents enrolled by each employee
- the health status of the enrolled employees and their dependents

Additional factors for employers with 15-99 employees

- the gender of enrolled employees
- your employer's industry

An additional factor for employers with 51-99 employees

- any applicable commission paid to sales representatives and brokers

Anthem HealthKeepers Open Access

When you'll be covered by Anthem HealthKeepers Open Access and another health care plan

Coordination of Benefits (COB) helps our members who are covered by more than one group health plan ensure they receive the benefits to which they are entitled while avoiding overpayment by either carrier. Because current and accurate information is the key to our Coordination of Benefits program, Anthem HealthKeepers Open Access members can expect to receive a COB questionnaire on an annual basis. Timely response to these questionnaires will help avoid delays in claims payment.

When a member is covered by two different group health plans, one is considered primary and the other is considered secondary. The primary carrier is the first to pay the claim and provides reimbursement according to plan allowances; the secondary carrier then provides reimbursement, typically covering the remaining allowable expenses.

Determining the primary versus secondary carrier

The following rules apply when determining which health plan is the primary carrier:

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

When a person is covered by 2 group plans, and	Then	Primary	Secondary
The person is covered as a dependent child and coverage is not stipulated in a court decree	The custodial parent's plan is	✓	
	The non-custodial parent's plan is		✓
The person is covered as a dependent child and the parents share joint custody	The plan of the parent whose birthday occurs earlier in the calendar year is	✓	
	The plan of the parent whose birthday is later in the calendar year is		✓
	Note: When the parents have the same birthday, the plan that has been in effect longer is	✓	

Medicare coverage is available to certain individuals who are under age 65. Payment coordination with Medicare is shown below:

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

Right of recovery

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

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

Anthem HealthKeepers Open Access

This list of services and supplies is excluded from coverage and will not be covered in any case. Your Anthem HealthKeepers Open Access coverage does not include benefits for:

A

- **acupuncture.**
- services received which are not **authorized in advance by us and pre-arranged by your primary care physician**, unless otherwise specified in this brochure.

B

- **biofeedback therapy.**

C

- over-the-counter **convenience** and hygienic items. These include, but are not limited to adhesive removers, cleansers, underpads, diapers and ice bags.
- **cosmetic surgeries** or procedures, including complications that result from such surgeries and/or procedures. Cosmetic surgeries and procedures are performed mainly to improve or alter a person's appearance, including body piercing and tattooing. However, a cosmetic surgery or procedure does not include a surgery or procedure to correct deformity caused by disease, trauma or a previous therapeutic process. Cosmetic surgeries and/or procedures also do not include surgeries or procedures to correct congenital abnormalities that cause functional impairment. We will not consider the patient's mental state in deciding if the surgery is cosmetic.

D

- the following **dental** or oral surgery services:
  - — shortening or lengthening of the mandible or maxillae for cosmetic purposes;
  - — surgical correction of malocclusion or mandibular retrognathia unless such condition creates significant functional impairment that cannot be corrected with orthodontic services;
  - — dental appliances required to treat TMJ pain dysfunction syndrome or correct malocclusion or mandibular retrognathia;
  - — medications to treat periodontal disease;
  - — treatment of natural teeth due to diseases or treatment of natural teeth due to accidental injury for which a treatment plan was not submitted to the HMO within 60 days of your date of injury; biting and chewing related injuries;
  - — restorative services and supplies necessary to promptly repair, remove or replace sound natural teeth;
  - — extraction of either erupted or impacted wisdom teeth; and
  - — anesthesia and hospitalization for dental procedures and services except for children under age five or those with conditions that put them at great risk.

These services are not covered under your Anthem HealthKeepers Open Access plan.

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

E

- **educational** or teacher services, except in limited services.

- **examinations** required specifically for insurance, employment, school, sports or camp. You do not have coverage for the cost of court-ordered examinations or care, including but not limited to, drug testing, unless such examinations or care are covered without a court order.

- **experimental/investigative** procedures as well as services related to or complications from such procedures except for clinical trials for cancer services as described by the National Cancer Institute. Nothing in this exclusion will prevent a member from appealing our decision that a service is experimental/investigative.

F

- the following **family planning** services:
  - — non-prescription contraceptive devices;
  - — infertility services including services for artificial insemination, in vitro fertilization, or any other types of artificial or surgical means of conception;
  - — drugs used to treat infertility; or
  - — reversals of sterilization and complications incidental to such procedures.

How new medical technologies are evaluated

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

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

These services are not covered under your Anthem HealthKeepers Open Access plan.

- services for palliative or cosmetic **foot** care including:
  - — flat foot conditions;
  - — support devices, arch supports, foot inserts, orthopedic and corrective shoes that are not part of a leg brace and fittings, castings and other services related to devices of the feet;
  - — foot orthotics;
  - — subluxations of the foot;
  - — corns (except as treatment for patients with diabetes or vascular disease);
  - — bunions (except capsular or bone surgery);
  - — calluses (except as treatment for patients with diabetes or vascular disease);
  - — care of toenails (except as treatment for patients with diabetes or vascular disease);
  - — fallen arches;
  - — weak feet;
  - — chronic foot strain; or
  - — symptomatic complaints of the feet.

H

- routine **hearing** care or hearing aids or exams for these devices except as outlined in this brochure.

- the following **home care services:**
  - — homemaker services (except as rendered as part of Hospice care);
  - — maintenance therapy;
  - — food and home delivered meals; or
  - — custodial care and services.

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

I

- **immunizations** required for travel and work, unless such services are received as part of the covered preventive care services.

M

- **medical equipment (durable), appliances, devices and supplies** that have both a non-therapeutic and therapeutic use. These include but are not limited to:
  - — exercise equipment;
  - — air conditioners, dehumidifiers, humidifiers and purifiers;
  - — hypoallergenic bed linens, bed boards;
  - — whirlpool baths;
  - — handrails, ramps, elevators and stair glides;
  - — telephones;
  - — adjustments made to a vehicle;
  - — foot orthotics;
  - — changes made to a home or place of business; or
  - — repair or replacement of equipment you lose or damage through neglect.

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

- services or supplies deemed not **medically necessary** by the HMO at its sole discretion. Notwithstanding this exclusion, all wellness services and hospice care services described in the benefits summary that is included with this brochure are covered. This exclusion shall not apply to services you receive on any day of inpatient care that is determined by the HMO to be not medically necessary if such services are received from a professional provider who does not control whether you are treated on an inpatient basis or as an outpatient, such as a pathologist, radiologist, anesthesiologist or consulting physician. Additionally, this exclusion shall not apply to inpatient services rendered by your admitting or attending physician other than inpatient evaluation and management services provided to you notwithstanding this exclusion. Inpatient evaluation and management services include routine visits by your admitting or attending physician for purposes such as reviewing patient status, test results, and patient medical records. Inpatient evaluation and management visits do not include surgical, diagnostic, or therapeutic services performed by your admitting or attending physician. Also, this exclusion shall not apply to the services rendered by pathologists, radiologists, or anesthesiologists in an (i) outpatient hospital setting (ii) emergency room or (iii) ambulatory surgery setting. However, this exception does not apply if and when any such pathologist, radiologist or anesthesiologist assumes the role of attending physician. Nothing in this exclusion shall prevent a member from appealing the HMO's decision that a service is not medically necessary.

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

N

- services administered by **non-network providers**, except for emergencies or when authorized in advance by the Anthem HealthKeepers Open Access Medical Director. (This exclusion does not apply for the Point of Service plans.)

- **nutrition** counseling and related services, except when provided as part of diabetes education.

O

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

- benefits for **organ or tissue transplants**, including complications caused by them, except when they are considered medically necessary, have received pre-authorization, and are not considered experimental/investigative.

These services are not covered under your Anthem HealthKeepers Open Access plan.

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

P

- **paternity testing.**

- as part of the **prescription drug** benefit coverage for:
  - — 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;
  - — cost of medicine that exceeds the allowable charge for that prescription;
  - — drugs for weight loss;
  - — stop smoking aids;
  - — therapeutic devices or appliances;
  - — injectable prescription drugs that are supplied by a provider other than a pharmacy;
  - — charges to inject or administer drugs;
  - — drugs not dispensed by a licensed pharmacy;
  - — drugs not prescribed by a licensed provider;
  - — any refill dispensed after one year from the date of the original prescription order;
  - — infertility medications;
  - — medications used to treat sexual dysfunction;
  - — medicine covered by workers' compensation, Occupational Disease Law, state or government agencies; or
  - — medicine furnished by any other drug or medical service.

R

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

- care from institutions or facilities that are licensed solely for residential treatment centers, intermediate care facilities, or other non-skilled, sub-acute inpatient settings.

S

- **services, supplies or devices** if they are:
  - — not listed as covered;
  - — not prescribed, performed or directed by a provider licensed to do so;
  - — received before the effective date or after a member's coverage ends; or
  - — telephone consultations, charges for not keeping appointments, charges for completing claim forms or other such charges.

- **services or supplies** if they are provided or available to a member:
  - — under a U.S. government program or a program for which the federal or state government pays all or part of the cost. This exclusion does not apply to health benefit plans offered to either civilian employees or retired civilian employees of the federal or state government.
  - — under the Medicare program or under any similar program authorized by state or local laws or regulations or any future amendments to them. This exclusion does not apply to those laws or regulations which make the government program the secondary payor after benefits under this plan have been paid.

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

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

- **services or benefits for:**
  - — amounts above the allowable charge for a service;
  - — self-administered services or self-care including self-administered injections;
  - — penile implants;
  - — self help training; or
  - — neurofeedback and related diagnostic tests.

- services for **sex transformation or sexual dysfunction.** This includes medical and mental health services.

- **services** of non-Anthem HealthKeepers Open Access providers, except for emergencies or when authorized in writing by our Medical Director including services not pre-arranged by your primary care physician and authorized in advance by us.
  - — women in at least their second trimester of pregnancy can continue to see their doctors who have left the Anthem HealthKeepers Open Access network, unless the doctors were asked to leave for cause.
  - — members with a terminal illness who are expected to live less than six months can continue to see their doctors who have left the Anthem HealthKeepers Open Access network, unless the doctors were asked to leave for cause.
    (This exclusion does not apply for the Point of Service plans.)

- the following **skilled nursing facility** stays:
  - — custodial care;
  - — treatment of psychiatric conditions and senile deterioration; or
  - — facility services during a temporary leave of absence from the facility.

- services related to **smoking cessation**, including stop smoking aids or services of stop smoking clinics.

- **spinal manipulations.**

T

- the following **therapies:**
  - — physical therapy, occupational therapy or speech therapy to maintain or preserve current functions if there is no chance of improvement or reversal except for children under age three who qualify for Early Intervention services;
  - — group speech therapy;
  - — group or individual exercise classes or personal training sessions; or
  - — recreation therapy. This includes, but is not limited to sleep, dance, arts, crafts, aquatic, gambling and nature therapy.

V

- the following **vision** services:
  - — vision services or supplies unless needed due to eye surgery or accidental injury;
  - — routine vision care except as outlined in this brochure;
  - — services for radial keratotomy and other surgical procedures to correct nearsightedness and/or farsightedness. 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 of any type;

— services needed for employment or given by a medical department, clinic or similar service provided or maintained by the employer; or

— any other vision services not specifically listed as covered.

W

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

The most detailed description of benefits, exclusions and restrictions can be found in the following which can be requested by calling Member Services at 1-800-421-1880 or 804-358-7390 (from Richmond):

Evidence of Coverage: HK-GEA (7/04), H-INTRO- (1/04), H-TOC (7/04), H-SB-HMO (7/04), H-SB-POS (7/04), H-WORKS (7/04), H-COVERED-HK (7/04), H-EXCL (7/04), H-CLAIMS-HK (1/04), H-COB (1/04), H-ENR (7/04), H-ENDS (7/04), H-INFO-HK (1/04), H-RIGHTS (7/04), H-DEF-HK (7/04), H-EXH-A (7/04), H-INDEX (7/04), H-FAMILY (1/04)

Enrollment applications for Anthem HealthKeepers Open Access offered by HealthKeepers, Inc.

490760 (4/04), 490760 (4/03), 490760.pdf (4/03), 490773 (4/04), 490773 (4/03), 490773.pdf (4/03), 490760 (7/03), 490760.pdf (7/03), 490773 (7/03), 490773.pdf (7/03), 110819 (4/03), 180305 (4/03), 181283 (4/03), 111578 (7/04)
AVA1143, AVA1144, AVA1145, AVA1146

This is not a contract or policy. This brochure is not a contract with HealthKeepers, Inc. It is a summary of benefits available through Anthem HealthKeepers Open Access offered by HealthKeepers, Inc. If there is any difference between this brochure and the Evidence of Coverage, Summaries of Benefits and related Amendments, the provisions of the Evidence of Coverage, Summaries of Benefits and related Amendments will govern.

HealthKeepers, Inc. and its Anthem HealthKeepers network of doctors, hospitals and other health care professionals shall incur no liability or obligation for delay, or failure to provide or arrange for health services if such failure or delay is caused by natural disaster, war, riot, civil insurrection, epidemic or any other emergency or similar event not within the control of HealthKeepers, Inc.

HealthKeepers, Inc. plans are not available in all areas of Virginia. For more information, please ask your employer or call Member Services at 1-800-421-1880 or 804-358-7390 (from Richmond).

Anthem HealthKeepers
Offered by HealthKeepers, Inc., Priority Health Care, Inc., and Peninsula Health Care, Inc.

Anthem HealthKeepers Essential Plan and Anthem HealthKeepers Standard Plan

The Essential and Standard Benefit plans were developed by the Commonwealth of Virginia for the purpose of increasing access to health care for Virginia's small business owners and their employees. Developed exclusively for companies in the 2-50 eligible employee market, all health insurance companies and health maintenance organizations (HMOs) that offer coverage to this market in Virginia must offer similar plans that provide for the coverage of certain medical services and certain benefit levels, as defined by the Commonwealth.

Summary of Rates for Essential and Standard Plans

Based on the group's specific CMF and area:

Rates are also available for these plans without dental coverage. Call for details.	Essential Benefit Plan with Dental	Standard Benefit Plan with Dental
Employee		
< 29	$158.94	$167.10
30 to 39	$182.68	$192.07
40 to 49	$219.83	$231.13
50 to 59	$338.10	$355.47
60 >	$478.57	$503.16
Plus Child		
< 29	$253.86	$266.90
30 to 39	$273.98	$288.05
40 to 49	$309.58	$325.48
50 to 59	$429.70	$451.77
60 >	$580.15	$609.96
Plus Children		
< 29	$389.43	$409.44
30 to 39	$406.40	$427.28
40 to 49	$435.12	$457.47
50 to 59	$561.30	$590.14
60 >	$708.37	$744.77
Plus Spouse		
< 29	$389.31	$409.31
30 to 39	$427.81	$449.79
40 to 49	$475.35	$499.77
50 to 59	$673.09	$707.67
60 >	$933.58	$981.54
Plus Family		
< 29	$552.73	$581.13
30 to 39	$612.65	$644.12
40 to 49	$673.24	$707.83
50 to 59	$871.84	$916.64
60 >	$1,043.52	$1,097.13

Summary of Benefits for Essential and Standard Plans

Following is a partial outline of major benefits available through these plans, which are administered on a calendar year basis:

Annual deductible (the amount a member must pay each calendar year before the plan begins to pay benefits)	None
Annual out-of-pocket expense limit per calendar year (does not apply to all services*)	$5,000 per person $15,000 per family
Lifetime maximum benefit limit (NOTE: Anthem HealthKeepers plans offered by Priority Health Care, Inc. have NO lifetime maximum benefit limit)	$1,000,000 per person (Does not apply to Priority Health Care, Inc.)
Covered Outpatient Medical Services	**Per Visit Copays:**
• Doctors' office visits	$20 PCP and Specialists
• X-rays, labs and diagnostic tests	$20
• Preventive care services	$20
• Hospital facility care (surgery, treatment of accidental injuries, emergency care)	$20
• Mental health and substance abuse visit (limited to 20 visits per member per calendar year)	$20
• Home health care (Standard plan only)	No copay
• Occupational, physical and speech therapy (Standard plan only)	$20
• Audiology services, including hearing aids (Standard plan only)	No copay
• Allergy testing and treatment (Standard plan only)	$20
Covered Inpatient Services	$400 per admission
• Medical, surgical and maternity admissions; ancillary services; semi-private room (Hospital care for mental health and substance abuse is limited to 21 days per calendar year.)	$20 per physician visit (No copays for plans offered by Priority Health Care, Inc.)
• Hospice care (Standard plan only)	No copay
• Skilled nursing home care (Standard plan only)	No copay
Outpatient Prescription Drugs • Limited to generic drugs, unless a generic is not available (based on generic drugs approved by the Virginia Voluntary Formulary Board) **Up to a 90-day supply for mail order*	$10 per prescription or refill
Vision Care Services	
• Standard Plan – covered for adults and children	No copay
• Essential Plan – covered for children age 17 and younger only	No copay
**Limited to one pair of lenses and frames per person per year*	(Excludes contact lenses)
Dental Services	
• Standard Plan – covered for adults and children	$20
• Essential Plan – covered for children age 17 and younger only	$20
**Routine exams and cleanings limited to 2 per person per year*	

***The following do not count toward the out-of-pocket expense limits for covered services under these plans:**

1. Copayments for outpatient mental health and substance abuse
2. Copayments for outpatient prescription drugs
3. Expenses for supplies or services not covered by the health plan
4. Amounts above the allowable charge
5. Copayments for dental or vision services
6. Amounts above plan limits

Anthem HealthKeepers
Offered by HealthKeepers, Inc., Priority Health Care, Inc.,
and Peninsula Health Care, Inc

Anthem HealthKeepers Essential Plan and Anthem HealthKeepers Standard Plan
The Essential and Standard Benefit plans were developed by the Commonwealth of Virginia for the purpose of increasing access to health care for Virginia's small business owners and their employees. Developed exclusively for companies in the 2-50 eligible employee market, all health insurance companies and health maintenance organizations (HMOs) that offer coverage to this market in Virginia must offer similar plans that provide for the coverage of certain medical services and certain benefit levels, as defined by the Commonwealth.

Summary of Benefits for Essential and Standard Plans
Following is a partial outline of major benefits available through these plans,
which are administered on a calendar year basis:

Annual deductible **(**the amount a member must pay each calendar year before the planbegins to pay benefits)	None
Annual out-of-pocket expense limit per calendar year (does not apply to all services*)	$5000 per person $15,000 per person
Lifetime maximum benefit limit (NOTE: Anthem HealthKeepers plans offered by Priority Health Care, Inc. have NO lifetime maximum benefit limit)	$1,000,000 per person (Does not apply to Priority Health Care)
Covered Outpatient Medical Services	**Per Visit Copays:**
·Doctors' office visits	$20 PCP and Specialists
·X-rays, labs and diagnostic tests	$20
·Preventive care services	$20
·Hospital facility care (surgery, treatment of accidental injuries, emergency care)	$20
·Mental health and substance abuse visit (limited to 20 visits per member per calendar year)	$20
·Home health care (Standard plan only)	No copay
·Occupational, physical and speech therapy (Standard plan only)	$20
·Audiology services, including hearing aids (Standard plan only)	No copay
·Allergy testing and treatment (Standard plan only)	$20
Covered Inpatient Services ·Medical, surgical and maternity admissions; ancillary services; semi-private room (Hospital care for mental health and substance abuse is limited to 21 days per calendar year.)	$400 per admission $20 per physician No copays for plans offered by Priority Health Care, Inc.)
·Hospice care (Standard plan only)	No copay
·Skilled nursing home care (Standard plan only)	No copay
Outpatient Prescription Drugs ·Limited to generic drugs, unless a generic is not available (based on generic drugs approved by the Virginia Voluntary Formulary Board) **Up to a 90-day supply for mail order*	$10 per prescription or refill
Vision Care Services	
·Standard Plan - covered for adults and children	No copay
·Essential Plan - covered for children age 17 and younger only **Limited to one pair of lenses and frames per year*	No copay (Excluded contact lenses)
Dental Services	
·Standard Plan - covered for adults and children	$20
·Essential Plan - covered for children age 17 and younger only **Routine exams and cleanings limited to 2 per person per year*	$20

***The following do not count toward the out-of-pocket expense limits for covered services under these plans:**

1. Copayments for outpatient mental health and substance abuse
2. Copayments for outpatient prescription drugs
3. Expenses for supplies or services not covered by the health plan
4. Amounts above the allowable charge
5. Copayments for dental or vision services
6. Amounts above plan limits