Key Advantage
Member Handbook

Effective July 1, 2018 (and October 1, 2018 for certain school groups)

The Local Choice Health Benefits Program
Administered by the Department of Human Resource Management
Commonwealth of Virginia

A10311 (5/2018)

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Key Advantage Health Benefits Plans
IMPORTANT NOTICE

Your Health Plan benefits are administered by Anthem Blue Cross and Blue Shield (BCBS) for Medical, Outpatient Prescription Drugs, Routine Vision, Behavioral Health and Employee Assistance Program (EAP). Under a separate agreement with Anthem BCBS, Delta Dental of Virginia administers the routine Diagnostic & Preventive and Comprehensive Dental benefits.

This booklet tells you what may be eligible for Reimbursement under Your Health Plan. Refer to your Benefits Summary insert to determine the specific amount you pay under the health plan in which you are enrolled. Throughout this booklet there are words which begin with capital letters. In most cases, these are defined terms. See the **Definitions** section for the meaning of these words.

Your Health Plan does not cover everything. There are specific Exclusions for which the program will never pay. Even more important, payment for services is almost always conditional. That is, payment may be reduced or even denied for a service if you received the service without observing all the conditions and limits under which the service is covered. Finally, you almost always have to pay for part of the cost of treatment.

Your health benefits are contractual in nature. This means, in part, that what you or your employer think is covered does not make it a covered service. Likewise, if you or your employer think a service should be covered, that does not make it a covered service. The same is true even when the issue is life or death: a service is not covered simply because you, your physician, or your employer believe you need the service, or because the service is the only remaining treatment which might (or might not) save your life. This booklet, along with your Benefits Summary insert, describes what services are eligible for Reimbursement, the conditions under which the services are covered, the limits of coverage, and the amounts which may be payable under the specified conditions. **You, and you alone, are responsible for knowing what is covered and the limits and conditions of coverage.** Furthermore, the terms and conditions of your coverage can be changed without your consent, if proper notice is given to you. This booklet may be printed at any time from the following Web site: **www.thelocalchoice.virginia.gov**.

Your Health Plan pays part of the cost of health services needed to diagnose and treat illnesses and injuries. Services designed primarily to improve your personal appearance are not eligible for Reimbursement. Services which are not necessary for the diagnosis and treatment of illnesses or injuries are not eligible for Reimbursement unless, in the sole judgment of the Plan Administrator, such services can reasonably be expected to avoid future costs to Your Health Plan.

There are some rules which apply to all benefits. See **General Rules Governing Benefits**. In addition, there are some services for which the Plan Administrator will never pay. See the **Exclusions** section. Also, we have included some rules governing Your Health Plan. See the **Basic Plan Provisions** section. Finally, refer to the **Definitions** section for an explanation of many of the terms used in this booklet. These sections are important because they will be used to determine exactly what Your Health Plan covers.

The Key Advantage plans are non-grandfathered health plans as defined by the Patient Protection and Affordable Care Act (PPACA).

IMPORTANT CONTACTS

Anthem Blue Cross and Blue Shield – Medical, Behavioral Health, Outpatient Prescription Drugs and Routine Vision
800-552-2682
For the hearing impaired, please contact your state's relay service by dialing 711.

Hours of Operation:
Monday-Friday 8:00 a.m. to 6:00 p.m. ET
Saturday 9:00 a.m. to 1:00 p.m. ET
www.anthem.com/tlc

Anthem Behavioral Health and Employee Assistance Program (EAP) (access to services and authorizations)
855-223-9277

Hours of Operation:
24 hours a day, 7 days a week
www.anthemeap.com
Password: Commonwealth of Virginia

Prescription Drug Home Delivery
800-355-8279

Hours of Operation:
24 hours a day, 7 days a week

Delta Dental of Virginia – Dental
888-335-8296

Hours of Operation:
Monday-Thursday 8:15 a.m. to 6:00 p.m. ET
Friday 8:15 a.m. to 4:45 p.m. ET
www.deltadentalva.com (Select The Local Choice link)

The Local Choice Health Benefits Program
www.thelocalchoice.virginia.gov

ID Card Order Line
866-587-6713

How to find a Provider
A directory of participating Providers may be accessed online at each Plan Administrator's website.

GET HELP IN YOUR LANGUAGE

Curious to know what all this says? We would be too. Here's the English version:
This notice has important information about your application or benefits. Look for important dates. You might need to take action by certain dates to keep your benefits or manage costs. You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (TTY/TDD: 711)

Spanish
Este aviso contiene información importante acerca de su solicitud o sus beneficios. Busque fechas importantes. Podría ser necesario que actúe para ciertas fechas, a fin de mantener sus beneficios o administrar sus costos. Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Amharic
ይህ ማስታወቂያ ስለማመልከቻዎ ወይም ጥቅማ ጥቅሞችዎ ጠቃሚ መረጃ አለው። አስፈላጊ ቀኖችን ይፈልጉ። ጥቅማ ጥቅሞችዎን ለማቆየት ወይም ክፍያዎችን ለመቆጣጠር በሆነ ቀን አንድ እርምጃ መውሰድ ያስፈልግዎ ይሆናል። ይህንን መረጃ እና እገዛ በቋንቋዎ በነጻ የማግኘት መብት አልዎት። ለእገዛ በመታወቂያዎ ላይ ያለውን የአባል አገልግሎቶች ቁጥር ይደውሉ። (TTY/TDD: 711)

Arabic
يحتوي هذا الإشعار على معلومات مهمة حول طلبك أو المزايا المقدمة لك. احرص على تتبع المواعيد المهمة. قد تحتاج إلى اتخاذ إجراء قبل مواعيد محددة للاحتفاظ بالمزايا أو لإدارة التكلفة. يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. يُرجى الاتصال برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة(TTY/TDD:711).

Bassa
Bɔ̃i-po-po nìà kɛ ɓéɖé bɔ̃ kpaɖɛ ɓá nì ɖɛ-mɔ́-ɖìfèɖè mɔɔ kpáná-ɖè ɓě m̀ ké dyéɛ dyí. M̀ mɛ mɔ́ wé kpaɖɛ ɓě dyi. Ɓé nì kpáná-ɖè ɓě ké m̀ xwa se mɔɔ ɓɛ́ m̀ ké píó xwa ɓɛ́ìn nyɛɛ, ɔ mu wɛ̃ìn ɓɛ́ m̀ kéɔ́ ɖɛ ɓě ti kɔ̃ nyùìn. M̀ ɓéɖé dyí-ɓèɖɛ̀in-ɖèɔ̀ ɓɛ́ m̀ ké bɔ̃ nìà kɛ kè gbo-kpá-kpá dyé ɖé m̀ ɓíɖí-wùɖùŭn bó pídyi. Ɖá Méɓà jè gbo-gmɔ̀ Kpòè nɔ̀ɓà nìà nì Dyí-dyoìn-bɛ̃ɔ̃ kɔ̃ɛ, bó gbo-kpá-kpá dyé jè. (TTY/TDD: 711)

Bengali
আপনার আবেদন বা সুবিধার বিষয়ে এই বিজ্ঞপ্তিটিতে গুরুত্বপূর্ণ তথ্য রয়েছে। গুরুত্বপূর্ণ তারিখগুলির জন্য দেখুন। আপনার সুবিধাগুলি বজায় রাখার জন্য বা খরচ নিয়ন্ত্রণ করার জন্য নির্দিষ্ট তারিখে আপনাকে কাজ করতে হতে পারে। বিনামূল্যে এই তথ্য পাওয়ার ও আপনার ভাষায় সাহায্য করার অধিকার আপনার আছে। সাহায্যের জন্য আপনার আইডি কার্ডে থাকা সদস্য পরিষেবা নম্বরে কল করুন। (TTY/TDD: 711)

Chinese
本通知有與您的申請或利益相關的重要資訊。請留意重要日期。您可能需要在特定日期前採取行動以維護您的利益或管理費用。您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

Farsi
این اطلاعیه حاوی اطلاعات مهم در مورد درخواست یا مزایای شما است. به تاریخهای مهم دقت کنید. ممکن است لازم باشد در برخی تاریخهای خاص اقدامی انجام دهید تا مزایای خود را حفظ کنید یا هزینه‌ها را مدیریت کنید. شما این حق را دارید که این

اطلاعات و کمکها را به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به شماره مرکز خدمات اعضاء که بر روی کارت شناسایی‌تان درج شده است، تماس بگیرید(TTY/TDD:711).

French
Cette notice contient des informations importantes sur votre demande ou votre couverture. Vous y trouverez également des dates à ne pas manquer. Il se peut que vous deviez respecter certains délais pour conserver votre couverture santé ou vos remboursements. Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. (TTY/TDD: 711)

German
Diese Mitteilung enthält wichtige Informationen zu Ihrem Antrag oder Ihren Beihilfeleistungen. Prüfen Sie die Mitteilung auf wichtige Termine. Möglicherweise müssen Sie bis zu einem bestimmten Datum Maßnahmen ergreifen, um Ihre Beihilfeleistungen oder Kostenzuschüsse aufrechtzuerhalten. Sie haben das Recht, diese Informationen und Unterstützung kostenlos in Ihrer Sprache zu erhalten. Rufen Sie die auf Ihrer ID-Karte angegebene Servicenummer für Mitglieder an, um Hilfe anzufordern. (TTY/TDD: 711)

Hindi
इस सूचना में आपके आवेदन या लाभों के बारे में महत्वपूर्ण जानकारी है। महत्वपूर्ण तिथियाँ देखें। अपने लाभ बनाए रखने या लागत का प्रबंध करने के लिए, आपको निश्चित तिथियों तक कार्रवाई करने की ज़रूरत हो सकती है। आपके पास यह जानकारी और मदद अपनी भाषा में मुफ़्त में प्राप्त करने का अधिकार है। मदद के लिए अपने ID कार्ड पर सदस्य सेवाएँ नंबर पर कॉल करें। (TTY/TDD: 711)

Igbo
Ọkwa a nwere ozi dị mkpa gbasara akwụkwọ anamachọihe ma ọ bụ elele gị. Chọgharịa ụbọchị ndi dị mkpa. Ị nwere ike ịme ihe n'ụfọdụ ụbọchị iji dowe elele gị ma ọ bụ jikwaa ọnụego. Ị nwere ikike ịnweta ozi a yana enyemaka n'asụsụ gị n'efu. Kpọọ nọmba Ọrụ Onye Otu dị na kaadị NJ gị maka enyemaka. (TTY/TDD: 711)

Korean
이 공지사항에는 귀하의 신청서 또는 혜택에 대한 중요한 정보가 있습니다. 중요 날짜를 살펴보십시오. 혜택을 유지하거나 비용을 관리하기 위해 특정 마감일까지 조치를 취해야 할 수 있습니다. 귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Russian
Настоящее уведомление содержит важную информацию о вашем заявлении или выплатах. Обратите внимание на контрольные даты. Для сохранения права на получение выплат или помощи с расходами от вас может потребоваться выполнение определенных действий в указанные сроки. Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте.
(TTY/TDD: 711)
Tagalog

May mahalagang impormasyon ang abisong ito tungkol sa inyong aplikasyon o mga benepisyo. Tukuyin ang mahahalagang petsa. Maaaring may kailangan kayong gawin sa ilang partikular na petsa upang mapanatili ang inyong mga benepisyo o mapamahalaan ang mga gastos. May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Urdu

یہ نوٹس آپ کی درخواست یا فائدوں کے بارے میں اہم معلومات پر مشتمل ہے۔ اہم تاریخیں دیکھیے۔ اپنے فائدوں یا لاگتوں کو منظم کرنےکے لیے آپ کو بعض تاریخوں پر اقدام کرنے کی ضرورت ہوسکتی ہے۔ آپ کو اپنی زبان میں مفت ان معلومات اور مدد کےحصول کا حق ہے۔ مدد کے لیے اپنے آئی ڈی کارڈ پر موجود ممبر سروس نمبر کو کال کریں۔ (TTY/TDD:711)

Vietnamese

Thông báo này có thông tin quan trọng về đơn đang ký hoặc quyền lợi bảo hiểm của quý vị. Hãy tìm các ngày quan trọng. Quý vị có thể cần phải có hành động trước những ngày nhất định để duy trì quyền lợi bảo hiểm hoặc quản lý chi phí của mình. Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

Yoruba

Àkíyèsí yìí ní ìwífún pàtàkì nípa ìbéèrè tàbí àwọn ànfàní rẹ. Wá déètì pàtàkì. O le ní láti gbé ìgbésẹ̀ ní déètì kan pàtó láti tọ́jú àwọn ànfàní tàbí ṣàkóso iye owó rẹ. O ní ẹ̀tọ́ láti gba ìwífún yìí kí o sì ṣèrànwọ́ ní èdè rẹ lọ́fẹ̀ẹ́. Pe Nọ́mbà àwọn ìpèsè ọmọ-ẹgbẹ́ lórí káàdì ìdánimọ̀ rẹ fún ìrànwọ́. (TTY/TDD: 711)

DEFINITIONS

Throughout this booklet are words which begin with capital letters. In most cases, these are defined terms. This section gives you the meaning of most of these words.

Activities of Daily Living
These are activities such as walking, eating, drinking, dressing, toileting, transferring (e.g. wheelchair to bed), and bathing.

Acute Care Facility
This is a Facility that provides Inpatient Medical care and other related services for surgery, acute Medical conditions or injuries (usually for a short term illness or condition).

Adult Incapacitated Dependents
These are adult children who have determined to be eligible (see Eligibility Section of this handbook) and been deemed incapacitated due to a physical or mental health condition. Once approved, coverage for these dependents is subject to periodic reviews.

Adverse Benefit Determination
This is a denial, reduction of a benefit or failure to provide a benefit, in whole or in part, by Your Health Plan.

AIM Specialty Health (AIM)
This is an Anthem owned utilization management organization that administers the Health Services Review process for diagnostic imaging services, sleep studies and sleep apnea treatment such as CPAP, chemotherapy and radiation therapy associated with cancer treatments. When your Provider calls Your Health Plan for these services, their call will be directed to AIM to complete the review.

Allowable Charge
This is the maximum amount that Your Health Plan will reimburse a Provider for a specific service. This is also the amount on which the Deductible (if any), Copayment, and Coinsurance for eligible services are calculated.

Applied Behavior Analysis
This is an educational component of autism spectrum disorder (ASD), which may include the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct Observation, measurement, and functional analysis of the relationship between environment and behavior.

Balance Bill
This refers to the amount a non-network Provider or Facility charges over the Allowable Charge that may be billed to you.

Behavioral Health
This includes the promotion and maintenance of mental and emotional health and wellness, and the treatment of substance abuse.

Benefits Administrator
The person appointed by your employer to assist you with Your Health Plan is your Benefits Administrator. Your Benefits Administrator may also provide you information about your benefits. If there is a conflict between what your Benefits Administrator tells you and Your Health Plan itself, your benefits, to the extent permitted by law, will be determined on the basis of the language in this booklet.

Coinsurance
The percentage of the Allowable Charge you pay for some covered services is your Coinsurance.

Concurrent Care Claim
This is a claim for a benefit where Your Health Plan is reducing or ending a service that it previously approved.

Copayment
The fixed dollar amount you pay for some covered services is your Copayment.

Covered Person
This is you and any enrolled eligible dependents.

Custodial Care
- Custodial care is defined as any services, supplies, care or treatment rendered to a beneficiary or member who:
  - is disabled mentally or physically as a result of a mental health/substance abuse diagnosis, and such disability is expected to continue and be prolonged;
  - requires a protected, monitored or controlled environment whether Inpatient, Outpatient, or at home;
  - requires assistance with Activities of Daily Living; and
  - is not under active and specific Medical, surgical, or psychiatric treatment that will reduce the disability to the extent necessary to enable the beneficiary or member to function outside the protected, monitored, controlled environment.

Deductible
Medical and Behavioral Health Services
This is the fixed dollar amount you pay for certain covered services in a Plan Year before Your Health Plan pays for those remaining covered services during that Plan Year. The Allowable Charge amount for those covered services is applied to the Deductible.

The Deductible amount is for a twelve month period and begins again each Plan Year.

The Deductible applies to benefits subject to a Coinsurance, such as ambulance travel, private duty nursing, infusion services, Medical Equipment and supplies, diagnostic tests, labs and x-rays. It does not apply to wellness, preventive, routine vision or drug benefits. Refer to the Benefits Summary for the plan in which you are enrolled for specific benefits.

Family Limit on Deductibles
Deductible amounts are calculated on an individual basis for each family member. This is how the Deductible works for each coverage type:

You Only: If you have single-only coverage, you are responsible for satisfying the single Deductible only.

You and One Family Member: Each of you must satisfy the individual Deductible.

Family: Deductible amounts for each individual member accumulate toward the family Deductible limit. However, no individual family member can contribute more than the single-only Deductible amount.

Carry Over Deductible
The Deductible amount is for a 12 month period and begins again each Plan Year. Deductible amounts incurred under this plan from April 1 through June 30 (July 1 – September 30 for certain school groups) carry over and are applied to the new Plan Year Deductible.

Dental Services
There is a separate Plan Year Deductible for the Comprehensive Dental option which applies to certain Dental benefits. The Dental Deductible works the same way as the Medical and Behavioral Health Deductible, except that the carry over provision *does not* apply to the Dental Deductible. The Dental Deductible does not count toward the Out-of-Pocket Expense Limit.

Dental
This refers to covered services for the care of your teeth and gums.

Effective Date
This is the date coverage begins for you and/or your dependents enrolled under Your Health Plan.

Emergency
An Emergency is the sudden onset of a Medical or Behavioral Health condition that manifests itself by symptoms of sufficient severity. This includes severe pain that without immediate Medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in:

- serious jeopardy to the physical health or Behavioral Health of the individual;
- danger of serious impairment of the individual's bodily 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.

Employee Assistance Program (EAP)
This is a free, voluntary, confidential service to help you, covered dependents and any members of your household deal with personal challenges that can be addressed through short-term counseling.

Episode of Care
This is the period of treatment between admission and discharge from a Facility.

Exclusions
These are services which are not, under any circumstances, eligible for Reimbursement under Your Health Plan. See the **Exclusions** section.

Experimental/Investigative
These are services or supplies that are judged to be Experimental or Investigative at the Plan Administrators' sole discretion. Refer to **Experimental/Investigative Criteria** under the **General Rules Governing Benefits** section.

Extended Coverage (COBRA) Qualified Beneficiary
This refers to you or a covered dependent who is covered on the day before a qualifying event, and who loses coverage due to that event. A child born to or placed for adoption with the covered employee during Extended Coverage or a participant whose coverage was terminated in anticipation of a qualifying event is also a qualified beneficiary.

Facility
Facilities that are covered under Your Health Plan include:
- Dialysis Centers
- Home Health Care Agencies
- Hospice Providers
- Hospitals
- Skilled Nursing Facilities

Health Services Review
This is the process of referring you to an appropriate Provider and reviewing your treatment plan to assure that you have the benefit under Your Health Plan, that the treatment is Medically Necessary, and that it is being delivered in the optimal Setting against Medical necessity criteria. The process may include referring you to an appropriate Provider for your condition.

Home Health Services
These are services rendered in the home Setting. Home Health Services include skilled nursing Visits and physical, speech, and occupational therapy for patients confined to their homes. Services also include home infusion therapy, which is the intravenous and parenteral administration of medication to patients, as well as enteral and parenteral nutrition. Home infusion therapy does not require that the patient be confined to his/her home.

Inpatient
This is a patient who has been in a hospital bed for at least 24 hours.

Inpatient Facility
This is a Setting where patients can spend the night, including hospitals and Skilled Nursing Facilities.

Intensive Outpatient Treatment Program (IOP)
Intensive Outpatient Treatment for Behavioral Health is an alternative to Inpatient or Partial Hospital care. It is a structured, short-term treatment that provides a combination of individual, group and family therapy.

It offers intensive, coordinated, multidisciplinary services for Covered Persons with an active psychiatric or substance related illness who are able to function in the community at a minimally appropriate level and present no imminent potential for harm to themselves or others.

Level of Care
This refers to the different types of Behavioral Health treatment Settings available to patients, including acute Inpatient, Residential Treatment, Partial Hospitalization, Intensive Outpatient Treatment, and Outpatient professional (office-based).

Maintenance Medication
This is a medication that you take routinely to treat or control a chronic illness such as heart disease, high blood pressure, or diabetes.

Medical
This refers to covered services for the screening, diagnosis and treatment of illness and disease.

Medical Equipment (durable)
This is equipment used for a Medical purpose, can withstand repeated use, and is appropriate for use in your home for daily living purposes.

Medically Necessary
To be considered Medically Necessary, a service must be:
- required to identify or treat an illness, injury, or pregnancy-related condition;
- consistent with the symptoms or diagnosis and treatment of your condition;
- in accordance with standards of generally accepted Medical practice; and
- 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.

Observation
Observation services are hospital Outpatient services given to help the doctor decide if the patient needs to be admitted as an Inpatient or can be discharged. The doctor has not written an order to admit the patient to the hospital as an Inpatient. Observation services may be given in the Emergency room or another area of the hospital.

Other Covered Services
This includes:
- ambulance services;
- Medical supplies; and
- equipment (including diabetic equipment, such as lancet devices and insulin pumps).

See the **Other Covered Services** section for a complete list.

Out-of-Network
When Providers, hospitals and other health care Providers/services have not contracted with the Plan Administrator to deliver health care services to its members, they are considered Out-of-Network.

Out-of-Pocket Expense Limit
This is the maximum amount of money that you pay out of your pocket for certain covered Medical, Behavioral Health and Outpatient Prescription Drug expenses (combined) during the Plan Year. There are separate Out-Of-Pocket Expense Limits for in-network and Out-of-Network services. The following count toward the Out-of-Pocket Expense Limit: Deductible, Copayment, and Coinsurance for covered services from Providers and Facilities in your Anthem and BlueCard PPO or Blue Cross Blue Shield Global Core Medical, Behavioral Health networks and Outpatient Prescription Drug services. Once the limit is reached, almost all other covered expenses are paid in full (100% of the Allowable Charge) for the rest of the Plan Year. The Out-of-Pocket Expense Limit is for a twelve month period and begins again each Plan Year.

Family Limit on Out-of-Pocket Expenses
The Out-of-Pocket Expense Limit is calculated on an individual basis for each family member. This is how the Out-of-Pocket Expense Limit works for each coverage type:

You Only: If you have single coverage, you are responsible for satisfying the single Out-of-Pocket Expense Limit only.
You and One Covered Family Member: Each of you must satisfy the individual Out-of-Pocket Expense Limit.

Family Coverage: Out-of-Pocket Expense Limit amounts for each individual member accumulate toward the family Out-of-Pocket Expense Limit. However, no individual covered family member can contribute more than the single-only Out-of-Pocket Expense Limit amount.

Outpatient
This is a patient who receives care in a hospital Outpatient department, Emergency room, professional Provider's office, Retail Health Clinic, Urgent Care Center, or the home.

Outpatient Behavioral Health Services
These are services for the diagnosis and treatment of psychiatric and substance abuse conditions and include individual psychotherapy, group psychotherapy, and psychological testing.

Outpatient Prescription Drugs
These are medicines, including insulin, that require a prescription order from your doctor.

Partial Day Hospitalization Program
This is intensive Behavioral Health treatment in a medically supervised Setting with the opportunity for the patient to return home or to another residence at night.

Plan Administrator
A Plan Administrator, also known as a Third Party Administrator (TPA), is an organization that provides claims administration. Your Health Plan benefits are administered by Anthem Blue Cross and Blue Shield (BCBS) for Medical, routine vision, Outpatient Prescription Drugs, and the Behavioral Health and Employee Assistance Program (EAP). Under a separate agreement with Anthem, Delta Dental of Virginia administers your routine Dental benefits. The Plan Administrator may send communications such as brochures or other materials that describe benefits under Your Health Plan. In the event of a conflict between this type of information and Your Health Plan, your benefits will be determined on the basis of the language in this booklet.

Plan Year
This is the period from July 1 through June 30 (October 1 – September 30 for certain school groups) for which Your Health Plan benefits are administered.

Plan’s Limiting Age
This is the end of the calendar year in which the dependent child turns age 26 and is no longer eligible for coverage.

Post-Service Claim
This is a claim filed after services are rendered and a claim that does not require authorization in advance of the service, even if you request authorization in advance.

Pre-Admission Testing
This procedure is conducted to determine if you are physically able to undergo Inpatient surgery under general anesthesia. This can include tests for blood work, chest x-ray, and/or EKG and is usually done prior to the procedure to ensure the surgery can proceed.

Precertification
This is a pre-service review that involves an advance clinical review and determination of Medical necessity related to Inpatient hospitalization (hospital admission review) or specific Outpatient services/procedures (Health Services Review). This process reviews your treatment plan to assure that the service/procedure is covered, Medically Necessary, and that the treatment is being delivered in the optimal Setting against Medical necessity criteria. The process also may include referring you to an appropriate Provider for your condition.

Pre-Service Claims
These are claims for a service where the terms of Your Health Plan require the member to obtain authorization of the benefit, in whole or in part, in advance of receipt of the service. If you call to receive authorization for a service when authorization in advance is not required, that claim will be considered a Post-Service Claim.

Primary Care Physician (PCP)
A general or family practitioner, internist or pediatrician can be designated as a PCP.

Providers
Providers must be licensed in the state where they perform the service you receive.
The following types of Providers may give care under Your Health Plan:

- addictionologists
- audiologists
- behavior analysts
- certified nurse midwives
- chiropractors
- chiropodists
- clinical social workers
- clinical psychologists
- Behavioral Health clinical nurse specialists
- dentists
- doctors of medicine (MD), including osteopaths and other specialists
- independent clinical reference laboratories
- marriage and family therapists
- neuropsychologists
- occupational therapists
- opticians
- optometrists
- podiatrists
- professional counselors
- psychiatrists
- registered physical therapists
- Retail Health Clinics
- speech pathologists

Reimbursement
This is the amount Your Health Plan pays for covered services.

Residential Treatment Program
This is specialized treatment in a licensed residential treatment center for psychiatric, substance abuse and other Medically Necessary therapeutic services that offers individualized and intensive treatment and includes:

- Observation and assessment by a psychiatrist or addictionologist weekly or more often; and
- Rehabilitation, therapy and education.

Residential treatment centers must be fully accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA).

Retail Health Clinic
This is a walk-in clinic located in a retail outlet such as a pharmacy or grocery store that provides a defined set of services for preventive health and basic health care problems. A Retail Health Clinic is staffed by Physician Assistants or Nurse Practitioners under the supervision of a physician.

Setting
This refers to the place where you receive treatment. It could be a Provider's office, Retail Health Clinic, Urgent Care Center, hospital Outpatient department, Skilled Nursing Facility, hospital Inpatient room, partial day program, or your home.

Shots (allergy and therapeutic injections)
Your Health Plan covers therapeutic injections (Shots) that a Provider gives to treat illness (e.g. allergy Shots) or pregnancy-related conditions. Also included is allergy serum for allergy Shots. In addition, you have coverage for immunizations and self-administered injections.

Some injections may be administered by pharmacies that are authorized to perform this service. Contact the pharmacy to determine if they are authorized to perform this service.

Skilled Nursing Facility
This is a Facility licensed by the state in which it operates to provide medically skilled services to Inpatients.

Specialty Care Providers
This includes any covered Providers other than those defined as Primary Care Physicians.

Specialty Drugs
These are typically higher cost brand name drugs used to treat chronic and rare conditions.

Stay
This is the period of time from the date you are admitted to a Facility to the date you are discharged from a Facility. If you are readmitted to a hospital for the same diagnosis within 90 days of the first Stay, it is considered the same Stay, and a new hospital Inpatient Copayment will not apply. If you are readmitted within 90 days for a different diagnosis, a new hospital Inpatient Copayment will apply.

Telemedicine
This is the use of interactive audio, video, or other electronic media for the purpose of diagnosis, consultation, or treatment as it pertains to the delivery of covered health care services.

The Local Choice Group
This means a local employer participating in The Local Choice Health Benefits Program.

The Local Choice Health Benefits Program
This means the health benefits program administered by the Department of Human Resource Management for the benefit of local governments, local officers, teachers, commissions, public authorities and other organizations created by or under an act of the General Assembly. The program may include other organizations designated by the General Assembly.

Tier 1 Drug
This is a lower cost drug, typically a generic drug.

Tier 2 Drug
This is a moderate cost drug, typically a multi-source brand name drug which has a generic equivalent.

Tier 3 Drug
This is a higher cost drug, typically a single source brand name drug which does not have a generic equivalent.

Tier 4 Drug
These are Specialty Drugs that are typically higher cost brand name drugs used to treat chronic and rare conditions.

Urgent Care Center
This is a center primarily used to treat patients who have an injury or illness that requires immediate care but is not serious enough to warrant a Visit to an Emergency room.

Visit
This is when a Covered Person meets with a Provider to receive covered services.

Your Health Plan
This is the Key Advantage plan in which you are enrolled.

GENERAL RULES GOVERNING BENEFITS

1) When a Charge Is Incurred
You incur the charge for a service on the day you receive the service.

2) When Benefits Start
Benefits will not be provided for any charges you incur before your Effective Date.

3) Services Must Be Medically Necessary
In all cases, benefits will be denied if the Plan Administrator determines, in its sole discretion, that care is not Medically Necessary.

4) When Benefits End
Benefits will not be provided for charges you incur after your coverage ends. There are two exceptions. If you are an Inpatient the day your coverage ends, your hospital coverage will continue until you are discharged to the extent that services were covered prior to the end of coverage. Also, Other Covered Services such as rental of Medical Equipment (durable) will be provided for a limited time for a condition for which you received covered services before your coverage ended. The time will be the shorter of when you become covered under any other group coverage, or the end of the Plan Year your coverage ends, or a period equal to the time you were enrolled under Your Health Plan.

5) Defining Services
When classifying a particular service, the Plan Administrator will use the most recent edition of a book published by the American Medical Association entitled Current Procedural Terminology (CPT). The Allowable Charge for a procedure will be based on the most inclusive code in “Current Procedural Terminology”. The Plan Administrator alone will determine the most inclusive code. No benefits will be provided for lesser included procedures or for procedures which are components of a more inclusive procedure.

6) Payment to Network Providers
The Plan Administrator pays the Allowable Charge which remains after your Copayment, Coinsurance, or Deductible to the network Provider. These amounts may be collected at the time of service. When you receive services from a network Provider, the Plan Administrator will make payment for these services directly to the Provider. If you have already paid the Provider you will need to return to the Provider for any Reimbursement. A Provider who participates in a Plan Administrator’s network will accept the Plan Administrator’s allowance as payment in full for that service.

7) Payment to Out-of-Network Medical or Behavioral Health Providers
When a member receives services from a non-network Medical or Behavioral Health services Provider, the Plan Administrator may choose to make payment directly to you or, at the Plan Administrator's sole option, to any other person responsible for payment of the Provider's charge. Payment will be made only after the Plan Administrator has received an itemized bill and the Medical information the Plan Administrator decides is necessary to process the claim. If the payment is made directly to you, you will be responsible for sending payment to the Provider. You also will be responsible for the difference between Your Health Plan’s allowance and the Provider's charge (Balance Bill). Payment by the Plan Administrator will relieve it and Your Health Plan of any further liability for the non-network Provider's services. **See your Benefits Summary insert to determine what you pay for Out-of-Network care.**

8) Alternative Benefits

Your Health Plan may elect to offer benefits for an approved, alternative treatment plan for a patient who would otherwise require more expensive services, including, but not limited to, long term Inpatient care. Your Health Plan will provide such alternative benefits at its sole option and only when and for so long as Your Health Plan decides that the alternative services are Medically Necessary and cost effective. The total benefits paid for such services may not exceed the total which would otherwise be paid under this contract without alternative benefits. If Your Health Plan elects to provide alternative benefits for a member in one instance, it will not be required to provide the same or similar benefits for any member in any other instance. Also, this will not be construed as a waiver of DHRM's right to administer this contract in the future in strict accordance with its express terms.

9) Organ and Tissue Transplants, Transfusions

Your Health Plan covers some but not all organ and tissue transplants. A Health Services Review is required to determine if a specific organ or tissue transplant service will be covered. When a human organ or tissue transplant is provided from a living donor to a Covered Person, both the recipient and the donor may receive the benefits of Your Health Plan. However, benefits for these services are limited only to those not available to the donor from any other source, including, but not limited to, other insurance coverage or any government program.

When only the donor is a Covered Person under Your Health Plan, only the organ donation procedure itself, including services rendered at the time of the organ donation procedure, are covered services. Any services provided prior to the organ donation procedures are not covered, whether Inpatient or Outpatient, even if they are provided in anticipation of the organ donation or as preparation for the organ donation.

Covered services for the identification of a suitable donor to a Covered Person for an allogeneic bone marrow transplant will include a computer search of established bone marrow registries and laboratory testing necessary to establish compatibility of potential donors. Donors may be from the patient's immediate family or have been identified through the computer search. These services must be ordered by a doctor qualified to provide allogeneic transplants.

10) Complaint and Appeal Process

You have access to both a complaint process and an appeal process. Should you have a problem or question about Your Health Plan, the appropriate Plan Administrator's Member Services Department will assist you. Most problems and questions can be handled in this manner. Anthem is the Plan Administrator for Medical, Behavioral Health and Employee Assistance Program (EAP), Outpatient Prescription Drug benefits and routine vision benefits. Delta Dental is the Plan Administrator for routine Dental services.

You may file a complaint or appeal. **Complaints** typically involve issues such as dissatisfaction about Your Health Plan's services, quality of care, the choice of and accessibility to Your Health Plan's Providers and network adequacy. **Appeals** typically involve a request to reverse a previous adverse decision made by Your Health Plan. You may also request to reopen a claim without invoking the appeal process when there are claim errors or claims are denied for insufficient information.

Complaint Process

Upon receipt, your complaint will be reviewed and investigated. You will receive a response within thirty (30) calendar days of the appropriate Plan Administrator's receipt of your complaint. If the Plan Administrator is unable to resolve your complaint within this time frame, you will be notified by the 30th calendar day that more time is required to resolve your complaint. The Plan Administrator will then respond to you within an additional thirty (30) calendar days.

Important: Written complaints or any questions concerning your coverage may be filed to the following addresses:

Anthem Blue Cross and Blue Shield (for Medical, Behavioral Health and Employee Assistance Program (EAP), Outpatient Prescription Drug and routine vision)
Attn: Member Services
P.O. Box 27401
Richmond, VA 23279

Delta Dental of Virginia (for Dental)
4818 Starkey Road, S.W.
Roanoke, VA 24018-8542

Claims Appeal Process

Your Health Plan is committed to providing a full and fair process for resolving disputes and responding to requests to reconsider a coverage decision you find unacceptable.

There are two types of claims appeals, internal and external. **Internal appeals** are filed to the Plan Administrator responsible for handling the claim. **External appeals** are filed to the Department of Human Resource Management (DHRM).

You or your authorized representative may request claims appeals on your behalf. However, appeal requests submitted by authorized representatives must be accompanied by a signed written statement from you that allows your authorized representative to act on your behalf.

Internal Appeals

An internal appeal is a request to reconsider an adverse coverage decision of a:

- **Pre-Service Claim** – a claim for a benefit under Your Health Plan for which you have not received the service or for which you may need to obtain approval in advance.
- **Post-Service Claim** – a claim for any benefit under Your Health Plan for which you have received the service.
- **Concurrent Care Claim** – a claim for a benefit where Your Health Plan is reducing or ending a service that it previously approved. **Note:** For Concurrent Care Claim appeals, the Plan Administrator must not reduce or terminate benefits prior to the resolution of the appeal.

What You May Appeal

You or your authorized representative may appeal any adverse determination by a Plan Administrator (Anthem or Delta Dental). An adverse determination is one that denies,

reduces, or terminates a covered benefit. You may also appeal adverse decisions involving a determination that the requested service is Experimental or Investigational.

In some circumstances, you have the right to an expedited internal appeal. See **Expedited Internal Appeals** for more information.

You have the right to request, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. "Relevant" means that the document, record, or other information:

- was relied on by the Plan Administrator in making the claim determination (including internal rules, guidelines, protocols, policies, guidance, or other criteria);
- was submitted, considered, or produced in the course of making the claim determination; or
- demonstrated that the claim determination was made in accordance with the terms of the plan.

The Plan Administrator will also provide you, free of charge, with copies of new or additional evidence considered. In addition, if you receive an adverse claim determination on a review based on new or additional evidence, the Plan Administrator will provide you, free of charge, with the rationale.

How to Request an Internal Appeal with the Plan Administrator

To file an internal appeal, you or your authorized representative must contact the Plan Administrator and provide the following information:

- your full name
- your identification number
- your address
- your telephone number
- the date(s) of the Medical service
- your specific Medical condition(s) or symptom(s)
- your Provider's name
- the service or supply for which approval of benefits is being sought, and
- any reasons why the appeal should be processed on an expedited basis.

When filing an internal appeal, you have the right to submit written comments, documents, records, and other information supporting your claim. The internal review will take into account all information that you submit, regardless of whether it was submitted or considered in the initial benefit determination.

You must file your appeal within 15 months of the date of service or 180 days from the date you were notified of the Adverse Benefit Determination, whichever is later.

Standard Internal Appeals

You or your authorized representative may request a **standard (non-expedited) internal appeal** of a Pre-Service Claim, Post-Service Claim, or a Concurrent Care Claim in writing by contacting the appropriate Plan Administrator at the address listed in **Addresses and Telephone Number for Appeals**.

Note that Anthem will accept standard appeals in writing or orally. Appeals to Anthem may be made by calling Anthem's telephone number below. Delta Dental appeals must be in writing.

Expedited Internal Appeals

You or your authorized representative may request, **either orally or in writing,** an **expedited internal appeal** of a Concurrent Care or Pre-Service Claim involving urgent Medical care. Situations in which expedited appeals are available include those involving prescriptions to alleviate cancer pain.

To file an expedited appeal, contact the appropriate Plan Administrator at the address or telephone number listed in **Addresses and Telephone Number for Appeals** below. Please indicate on the envelope, fax cover sheet, or during the telephone call that you would like for the appeal to be expedited. **Note:** Appeals to Delta Dental may only be filed in writing.

Expedited internal appeals must be resolved within seventy-two (72) hours after receipt of the appeal request.

Addresses and Telephone Number for Appeals

Anthem Address**:**	Anthem Blue Cross and Blue Shield Attn: Corporate Appeals Department P.O. Box 27401 Richmond, VA 23279 Telephone: **800-552-2682**
Delta Dental Address:	Delta Dental of Virginia Attn: Appeals 4818 Starkey Road, S.W. Roanoke, VA 24018-8542

How the Plan Administrator Will Handle Your Appeal

In reviewing your appeal, the Plan Administrator will take into account all the information you submit, regardless of whether the information was considered at the time the initial decision was made.

The Plan Administrator will resolve and respond in writing to your appeal within the following time frames:

- for expedited appeals, the Plan Administrator will respond orally within seventy-two (72) hours and will follow up with written confirmation of its decision within twenty-four (24) hours.
- for standard Pre-Service Claim appeals, the Plan Administrator will respond in writing within thirty (30) days after receipt of the request to appeal;
- for standard Post-Service Claim appeals, the Plan Administrator will respond in writing within sixty (60) days after receipt of the request to appeal;
- for Concurrent Care Claim appeals, the Plan Administrator will respond in writing within thirty (30) days after receipt of the request to appeal and prior to the benefits being reduced or terminated.

When the Plan Administrator has completed its review of your appeal, you will receive written notification of the outcome.

External Claims (DHRM) Appeals

After internal appeals are exhausted, you may request an external appeal to DHRM.

For external appeals, you may only appeal Adverse Benefit Determinations by the Plan Administrator that are based on Your Health Plan's requirements for medical necessity, appropriateness, health care Setting, Level of Care, effectiveness of a covered benefit, or the failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational.

Just as with internal appeals, in some circumstances, you have the right to an expedited external appeal. See **Expedited External Appeals** below for more information.

You or your authorized representative must submit the following information to the Director of the Virginia Department of Human Resource Management (DHRM):

- your full name
- your identification number
- your address
- your telephone number
- the date(s) of the Medical service
- your specific Medical condition(s) or symptom(s)
- your Provider's name
- the service or supply for which approval of benefits is being sought, and
- any reasons why the appeal should be processed on an expedited basis.

You may also submit any additional information you wish to have considered in this review. However, you do not have to re-send any information that you sent to the Plan Administrator to consider during your internal appeal.

Claims appeals will be referred to an independent review organization that will render a written decision. The decision is binding on Your Health Plan, but if the decision is not in your favor, you have the right to further appeal to the circuit court under the Administrative Process Act. The circuit court ruling is binding on all parties. The Virginia Administrative Process Act addresses court review of administrative decisions at the Code of Virginia §2.2-4025 through Code of Virginia §2.2-4030. Part 2A of the Rules of the Virginia Supreme Court addresses appeals through the Administrative Process Act.

Standard External Appeals

Standard (non-expedited) external appeals must be submitted in writing to DHRM by traditional mail, email or facsimile within four (4) months after the final adverse decision by your Plan Administrator.

You may download an appeals form at **www.thelocalchoice.virginia.gov**.

To appeal by traditional mail, send your request to the following address:

Director, Virginia Department of Human Resource Management
101 N. 14th Street – 12th Floor
Richmond, VA 23219

Please mark the envelope: Confidential – Appeal Enclosed.

To use email, send your request to **appeals@dhrm.virginia.gov**

To use facsimile, fax your request to **804-786-0356**.

If your appeal request is incomplete or ineligible for external review, DHRM will inform you within six (6) business days of the reason(s) for ineligibility and what information or materials are needed to make your appeal request complete.

If your appeal request is complete and eligible for external review, DHRM will notify you within six (6) business days of the name and contact information of the independent review organization deciding your appeal. You will then have five (5) business days to provide any additional information to the independent review organization. The independent review organization has the discretion to accept additional information provided after this deadline.

Within forty-five (45) days after the independent review organization receives your appeal request, the independent review organization will send you or your authorized representative written notification of its decision.

Expedited External Appeals

Expedited external appeals may be submitted to DHRM by telephone, facsimile or email at the time that you receive:

- an adverse decision from your Plan Administrator, if the adverse decision involves a Medical condition for which the time frame for completing an expedited internal appeal (see **Expedited Internal Appeals** above) would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, and you or your authorized representative has requested an expedited internal appeal from the Plan Administrator;
- a final adverse decision of an internal appeal from the Plan Administrator, if the adverse decision involves a Medical condition for which the time frame for completing a standard external appeal (see **Standard External Appeals** above) would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final adverse decision concerns an admission, availability of care, continued Stay, or health care service for which you received Emergency services, but have not been discharged from a Facility; or
- a final adverse decision of an internal appeal from the Plan Administrator, if the adverse decision involves prescriptions to alleviate cancer pain.

If you intend for your appeal to be expedited, clearly write "expedited" on the appeal request (and envelope, fax cover sheet, or email subject line as appropriate).

To appeal by traditional mail, send your request to the following address:
Director, Virginia Department of Human Resource Management
101 N. 14th Street – 12th Floor
Richmond, VA 23219

Please mark the envelope: Confidential – Expedited Appeal Enclosed.

To use email, send your request to **appeals@dhrm.virginia.gov**

To use facsimile, fax your request to **804-786-0356**.

To appeal by telephone, call **804-786-0353**.

If your appeal request is either incomplete or ineligible for external review, DHRM will promptly notify you of the reason(s) for ineligibility.

If your expedited appeal is complete and eligible for external review, the independent review organization will notify you or your authorized representative of its decision within 72 hours of the independent review organization's receipt of your appeal request. If this notification is given verbally, the independent review organization will send you or your authorized representative a written decision within 48 additional hours.

However, if the expedited appeal involves a determination that a requested Medical service is Investigational or Experimental, then the following rules apply.

- The appeal must be accompanied by a written certification from your treating physician that the health care service or treatment would be significantly less effective if not promptly started.
- If your appeal request is either incomplete or ineligible for external review, DHRM will promptly notify you of the reason(s) for ineligibility.
- If your appeal is complete and eligible for external review, the independent review organization will notify you of its decision within seven (7) business days. If this notification is given verbally, a written notice will follow within 48 hours.

Other Appeals to DHRM

If an appeal involves an adverse eligibility determination (these are adverse determinations made by DHRM), then it should be submitted in writing to the Director of the Virginia Department of Human Resource Management (DHRM). Appeals to the Director must be filed within four (4) months of Your Health Plan's action or appropriate notification of that action, whichever is later.

To file such an appeal, you or your authorized representative must submit the following information to the Director of DHRM:

- your full name
- your identification number
- your address
- your telephone number
- a statement of the adverse decision you are appealing, and
- what specific remedy you are seeking in filing this appeal

You may download an appeals form at **www.dhrm.virginia.gov**
To appeal by traditional mail, send your request to the following address:

Director, Virginia Department of Human Resource Management
101 N. 14th Street – 12th Floor
Richmond, VA 23219

Please mark the envelope: Confidential – Appeal Enclosed.

To use email, send your request to **appeals@dhrm.virginia.gov**
To use facsimile, fax your request to **804-786-0356**.

You have the right to submit written comments, documents, records, and other information supporting your claim. The appeal will take into account all information that you submit, regardless of whether it was submitted or considered in the initial determination.

DHRM does not accept appeals for matters in which the sole issue is disagreement with policies, rules, regulations, contract or law. If you are unsure whether an eligibility determination can be appealed, call the Office of Health Benefits at **804-225-3642** or **888-642-4414.**

You are responsible for providing DHRM with all information necessary to review the denial of your claim. You will be allowed to submit any additional information you wish to have considered in this review, and you will have the opportunity to explain, in person or by telephone, why you think the determination should be overturned.

These appeals will be decided by the Director of DHRM, who will render a written decision. If the decision is not in your favor, you have the right to further appeal through the Virginia Administrative Process Act. The circuit court ruling is binding on all parties. The Virginia Administrative Process Act addresses court review of administrative decisions at the Code of Virginia §2.2-4025 through Code of Virginia §2.2-4030. Part 2A of the Rules of the Virginia Supreme Court addresses appeals through the Virginia Administrative Process Act.

11) Coordination of Benefits (COB)

COB helps to prevent duplicate payments from benefit plans for the same services. COB is an important provision because it helps to control the cost of your health care coverage. COB rules apply when you or members of your family have additional health care coverage through other group health plans, including:

- group insurance plans, other Blue Cross and Blue Shield plans or HMO plans or other dental plans;
- labor management trustee plans, union welfare plans, employer welfare plans, employer organization plans, or employee benefit organization plans; and
- coverage under any tax-supported or government program to the extent permitted by law.

If you are a new enrollee, you will receive and will be required to respond to a COB inquiry letter following your enrollment in the health plan. You should notify the appropriate plan administrator (Anthem and/or Delta Dental) if your coverage changes during your enrollment in this plan. You are responsible for ensuring that Anthem has accurate, up-to-date information on file. This means notifying Anthem if you add other coverage, change existing coverage or your other coverage is cancelled.

Primary Coverage and Secondary Coverage
When a Covered Person is also enrolled in another group health plan, one coverage will be primary and one will be secondary. The decision of which coverage will be primary or secondary is made using the order of benefit determination rules. Highlights of these rules are described below.

- If the other coverage does not have COB rules substantially similar to Your Health Plan's, the other coverage will be primary.
- If a Covered Person is enrolled as the employee under one coverage and as a dependent under another, generally the one that covers him or her as the employee will be primary.
- If a Covered Person is the active employee under both coverages, generally the one that covers him or her for the longer period of time will be primary.
- If the dependent is covered as a dependent on their parent(s) plan and they are also covered as a dependent on their spouse's plan, the spouse's plan is primary.
- If the Covered Person is enrolled as a dependent child under both coverages (for example, when both parents cover their child), typically the coverage of the parent whose birthday falls earliest in the calendar year will be primary.
- Special rules apply when a Covered Person is enrolled as a dependent child under two coverages and the child's parents are living apart. Generally, the coverage of the parent or step-parent with custody will be primary. However, if there is a court order that requires one parent to provide health care for the child, that parent's coverage will be primary. If there is a court order that states that the parents share joint custody without designating that one of the parents is responsible for Medical expenses, the coverage of the parent whose birthday falls earliest in the calendar year will be primary.
- If a covered active employee or employee's dependent also has other coverage as a retiree or laid off employee, the active coverage is primary and the other coverage is secondary.
- If a covered active employee or employee's dependent is also covered by Medicare, the coverage provided by the employer is primary (unless Medicare eligibility is due to End Stage Renal Disease and the coordination period has been exhausted).
- If a covered retiree, survivor or their covered dependent is eligible for Medicare, the Medicare-eligible member is no longer eligible for coverage under Your Health Plan (except during an End Stage Renal Disease coordination period). Refer to the **Eligibility, Enrollment and Changes** section of the handbook under **When You Become Eligible for Medicare** for more information.

When Your Health Plan is the primary coverage, it pays first. When Your Health Plan is the secondary coverage, it pays second as follows.

- The Plan Administrator calculates the amount Your Health Plan would have paid if it had been the primary coverage, then coordinates this amount with the primary plan's payment. Your Health Plan's payment in combination with the other plan's payment will never exceed the amount Your Health Plan would have paid if it had been your primary coverage.
- Some plans provide services rather than making a payment (i.e., a group model HMO). When such a plan is the primary coverage, Your Health Plan will assign a reasonable cash value for the services and that will be considered the primary plan's payment. Your Health Plan will then coordinate with the primary plan based on that value.
- In no event will Your Health Plan pay more in benefits as secondary coverage than it would have paid as primary coverage.

12) Overpayment of Benefits

If Your Health Plan overpays benefits, your plan has the right to recover the excess from:

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

You will be required to cooperate with Your Health Plan to secure this right.

13) Out-of-Pocket Expense Limit

When you reach the Out-of-Pocket Expense Limit for covered Medical, Behavioral Health and Outpatient Prescription Drug services in a Plan Year, almost all other covered Medical and Behavioral Health services are paid at 100% of the Allowable Charge for the rest of the Plan Year. There are separate Medical, Behavioral Health and Outpatient Prescription Drug Out-Of-Pocket Expense Limits for in-network and Out-of-Network services.

*Expenses that **count** toward your Out-of-Pocket Expense Limit:*

- Deductible, Copayments and Coinsurance for covered services from Providers and Facilities in your Anthem or BlueCard/BCBS Global Core PPO Medical and Behavioral Health networks and Outpatient Prescription Drug services.
- Copayments for covered routine eye exams for members through the end of the month they turn 19.

*Expenses that **do not count** toward your Out-of-Pocket Expense Limit:*

- services or supplies not covered by Your Health Plan;
- amounts above the Allowable Charge;
- amounts above the health plan limits;
- *the difference between the Allowable Charge for a brand name Outpatient Prescription Drug and the Allowable Charge for its generic equivalent;* and
- Copayments, Deductibles and Coinsurance for Routine Vision (except routine eye exam for members through the end of the month they turn 19), and Dental services.

14) Notice from the Plan Administrator to You

A notice sent to you by the Plan Administrator is considered "given" when delivered to The Local Choice Group or your Group Benefits Administrator at the address listed in the Plan Administrator's records. If the Plan Administrator must contact you directly, a notice sent to you by the Plan Administrator is considered "given" when mailed to the member at the member's address listed in the Plan Administrator's records. Be sure that your Group Benefits Administrator has your current home address.

15) Notice from You to the Plan Administrator

Notice by you or your Group Benefits Administrator is considered "given" when delivered to the Plan Administrator. The Plan Administrator will not be able to provide assistance unless the member's name and identification number are in the notice.

16) Work-related Injuries or Diseases

Your Health Plan does not include benefits for services or supplies that are for work-related injuries or diseases when the employer, or worker if self-employed, must provide benefits by federal, state, or local law or when that person’s work related health claims have been paid by the employer. This Exclusion applies even if you waive your right to payment under these laws and regulations or fail to comply with procedures to receive the benefits. It also applies

whether or not the Covered Person reaches a settlement with his or her employer or the employer's insurer or self-insurance association because of the injury or disease.

17) Subrogation

Your Health Plan does not include subrogation. Your Health Plan will not seek to recover claims payments from responsible parties when a member is injured or becomes ill through the fault of another person.

18) Fraud and Abuse

If you suspect fraud or abuse involving a claim, please notify the Plan Administrator by calling Member Services to report the matter for investigation.

19) Voluntary Health Services Review

For surgical services, especially for high cost services, it is recommended that you have your Provider call Anthem to see if the service is covered in advance of receiving services and it's your responsibility to ensure the review has been done. You can also request a voluntary Health Services Review directly with Anthem. **If you sign a financial waiver from the Provider or hospital then you may be responsible for services not covered by the health Plan Administrator.**

20) Experimental/Investigative Criteria

Experimental/Investigative means any service or supply that is judged to be Experimental or Investigative at the Plan Administrator's sole discretion. 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 three standard reference compendia defined below:
        1. the U.S. Pharmacopoeia Dispensing Information
        2. the American Medical Association Drug Evaluations
        3. the American Hospital Formulary Service Drug Information, or
        4. 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 the Plan Administrator 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.

21) Clinical Trial Costs

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

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:

   a) the National Institutes of Health.

   b) the Centers for Disease Control and Prevention.

   c) the Agency for Health Care Research and Quality.

   d) the Centers for Medicare & Medicaid Services.

   e) cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.

   f) a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

   g) any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

      i. the Department of Veterans Affairs.

      ii. the Department of Defense.

      iii. the Department of Energy.

2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration (FDA);
3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Your Health Plan may require you to use an in-network Provider to maximize your benefits. When a requested service is part of an approved clinical trial, it is a covered service even though it might otherwise be Investigational as defined by Your Health Plan. All requests for clinical trial services, including requests that are not part of approved clinical trials, will be reviewed according to our Clinical Coverage Guidelines related policies and procedures.

Your Health Plan is not required to provide benefits for the following services. We reserve our right to exclude any of the following services:

- the Investigational item, device, or service, itself; or
- items and services that are given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
- a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; or
- any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

FACILITY SERVICES

HOSPITAL SERVICES

The charges made by a hospital for use of its facilities and services are eligible for Reimbursement under many circumstances.

Services Which Are Eligible for Reimbursement

1) Emergency room services leading directly to admission or which are rendered to a patient who dies before being admitted. In an Emergency, go to the nearest appropriate Provider or Medical Facility. For Medical admissions, call Anthem member services to obtain Hospital Admission Review. For Behavioral Health admissions, contact Anthem Behavioral Health.

2) Bed and board in a semi-private room, including general nursing services and special diets. A bed in an intensive care unit is eligible for Reimbursement for critically ill patients. Your Health Plan covers the charge for a private room if you need a private room because you have a highly contagious condition; you are at greater risk of contracting an infectious disease because of your Medical condition; or if the hospital only has private rooms. Otherwise, you have coverage for a semi-private room. If you choose to occupy a private room, you will be responsible for paying the daily differences between the semi-private and private room rates in addition to any Copayment or Coinsurance that may apply.

3) Customary ancillary services for Inpatient Stays, including operating rooms, medications, oxygen and oxygen tents, dressings and casts, anesthesia, transfusions, diagnostic tests and therapy services, professional ambulance services for transportation between local hospitals when Medically Necessary, and routine nursery care of a newborn as part of a mother's covered maternity service.

4) If complications arise during a newborn's confinement or if the newborn does not go home with the mother, a Hospital Admission Review would be required for the newborn. Eligibility criteria must be met for the newborn to receive benefits. Newborns must be added to the health plan within the timeframe allowed by the group's flexible benefits document and no more than 60 days of the date of birth.

5) Detoxification and Residential Treatment for Behavioral Health services. These services are available on the same basis as Inpatient services.

6) Outpatient hospital services including Observation services, Pre-Admission Testing and other diagnostic tests, therapy services, Shots, prescription medications received during treatment, surgical services, mammography, routine colonoscopy screening and Intensive Outpatient Treatment and Partial Day Hospitalization for Behavioral Health.

7) Dialysis treatment, which is the treatment of severe kidney failure or chronic poor functioning of the kidneys. This includes hemodialysis and peritoneal dialysis.

8) The cost of blood, blood plasma, blood derivatives, storage of blood by a hospital or professional donor fees.

9) The Key Advantage Expanded and Key Advantage 250 health plans offer an incentive if you enroll in the Future Moms maternity program within your first trimester and meet other required criteria. Refer to the section for **Programs Included in Your Health Plan** for more information about the program and incentive requirements.

Conditions for Reimbursement

1) Inpatient and Outpatient hospital services (including Observation services) must be:

   - prescribed by a Provider licensed to do so;
   - furnished and billed by a licensed and accredited hospital; and
   - Medically Necessary.

2) In addition to any Copayment, Coinsurance and Deductible that apply, you may be financially responsible for the entire hospital bill if, after your admission to the hospital, the Plan Administrator finds that the Inpatient Stay was not Medically Necessary. In order to avoid this, you should comply with the following hospital admission review procedure:

   a. You, your Provider, or someone you authorize should contact the Plan Administrator by telephone or by letter prior to a non-Emergency Inpatient service and furnish the following information:

      - physician's name, address, and telephone number;
      - name and address of the hospital to which your admission is planned;
      - your name and member identification number;
      - anticipated admission date and length of Stay; and
      - Medical justification for Inpatient treatment.

      After an Emergency admission, you, your physician, the admitting physician, a family member, or a friend should contact the Plan Administrator within 48 hours or, if later, the next business day after the admission to furnish the above information.

   b. You, your physician, the admitting physician, a family member, or a friend must receive a response from the Plan Administrator, either approval or disapproval, prior to the rendering of the non-Emergency Inpatient service.

   The Plan Administrator will respond to a hospital admission review request within 24 hours after its receipt. The Plan Administrator may request additional information in order to determine whether to approve or disapprove benefits for an Inpatient service. In this case, the Plan Administrator will respond with an approval or disapproval within 24 hours after the necessary information is supplied.

   Hospital admissions for a covered laparoscopy-assisted vaginal hysterectomy will be approved for a period no less than 23 hours. Hospital admissions for a covered vaginal hysterectomy will be approved for a period no less than 48 hours unless otherwise determined by your Provider.

   Admissions for maternity care do not initially require hospital admission review. The length of Stay for maternity admissions is determined according to the Newborn’s and Mother’s Health Protection Act. The federal law allows for 48 hours for vaginal delivery and 96 hours for cesarean section. However, if complications develop and additional days are necessary,

hospital admission review is required. Have your doctor contact Anthem to establish eligibility.

Refer to the **Other Federal Notices** section for **Women's Health and Cancer Rights**.

If, as a part of the hospital admission review program, the Plan Administrator determines that a contemplated Inpatient service is not Medically Necessary and the member elects to proceed with the Inpatient service despite this determination, the Plan Administrator will deny this service as not Medically Necessary unless additional information is provided indicating a contrary result is warranted. You are financially responsible for hospital services which are not Medically Necessary.

3) A Health Services Review, which is performed by AIM Specialty Health (AIM) on behalf of Anthem, is required for diagnostic imaging services including:

   - cardiac nuclear studies (such as cardiac stress tests);
   - computed tomography (CT), computed tomographic angiography (CTA) scans;
   - magnetic resonance imaging (MRI), magnetic resonance angiography (MRA);
   - magnetic resonance spectroscopy (MRS);
   - positron emission tomography (PET); and
   - single photon emission computed tomography (SPECT) scans

   This list of services is only a sampling and may change, so always check with your Provider or Plan Administrator's Member Services for the most current and complete list. While there is no penalty if the pre-service is not performed in advance of receiving the service, the advantage of the pre-service review is that you and your Provider know beforehand whether the service is appropriate, Medically Necessary, and meets coverage guidelines. If advance approval is not obtained, payment of the claim may be delayed. Also, if the service is later determined not to be Medically Necessary, you may have to pay for the service.

4) If specialty care is required and it is not available from a Provider within the network, your Provider can call Anthem in advance of your receiving care to request authorization for coverage. If Out-of-Network care is authorized by Your Health Plan, you will be responsible for the difference between Your Health Plan's Allowable Charge and the Provider's charge (Balance Bill).

5) Key Advantage Expanded and Key Advantage 250 ONLY - Emergency room services may have an Outpatient Facility Copayment as well as Coinsurance for diagnostic tests, labs and x-rays. If you are transferred from one Emergency room to another and admitted at the second hospital, you are only responsible for the Inpatient Copayment to the second hospital. The first Emergency room Visit would be covered at 100% of the Allowable Charge.

6) Key Advantage Expanded and Key Advantage 250 ONLY - The Outpatient Facility service Copayment will not be applied if an Emergency room Visit results in Outpatient surgery or an Observation Stay. The Emergency room Copayment and other applicable Deductible, Copayments and Coinsurance associated with the Emergency room Visit, Outpatient surgery and Observation Stay will be applied.

Special Limits

None.

Health Plan Reimbursement

Your Health Plan pays the remaining Allowable Charge after your Deductible, Copayment or Coinsurance for covered services in a network hospital during approved admissions.

Member Pays

Refer to the Benefits Summary for the plan in which you are enrolled.

SKILLED NURSING FACILITY SERVICES

Services Which Are Eligible for Reimbursement

1) Your Health Plan will cover your semi-private room in a network Skilled Nursing Facility. The room charge includes your meals, any special diets, and general nursing services. You are also entitled to receive the same types of ancillary services which are available to a hospital Inpatient.

2) Your Health Plan will cover the private room charge if you need a private room because you have a highly contagious condition or are at greater risk of contracting an infectious disease because of your Medical condition. Otherwise, your Inpatient benefits will cover the Skilled Nursing Facility's charges for a semi-private room. If you choose to occupy a private room, you will be responsible for paying the daily differences between the semi-private and private room rates in addition to your Copayment and Coinsurance (if any).

Conditions for Reimbursement

1) Care which is necessary for a person who does not have a treatable Medical illness or injury is not covered. For example, a person is not eligible for covered care in a Skilled Nursing Facility simply because the person is unable to care for him or herself (that is, the person cannot perform several Activities of Daily Living, such as bathing or feeding).

2) Skilled Nursing Facility Services must also be:

   - medically skilled services;
   - prescribed by your Provider and listed in the plan of treatment;
   - furnished and billed for by the Skilled Nursing Facility; and
   - Medically Necessary.

3) You may be financially responsible for the entire Skilled Nursing Facility bill if, after your admission to the Skilled Nursing Facility, the Plan Administrator finds that the Inpatient Stay was not Medically Necessary. In order to avoid this, you should comply with the following procedure.

   a. You, your physician, the admitting physician, family member, or a friend should contact the Plan Administrator by telephone or by letter prior to a non-Emergency Inpatient service and furnish the following information:

      - physician's name, address, and telephone number;
      - name and address of the Skilled Nursing Facility to which your admission is planned;
      - your name and member identification number;
      - anticipated admission date and length of Stay; and
      - Medical justification for Inpatient treatment.

   b. You or your physician must receive a response from the Plan Administrator, approval or disapproval, prior to the rendering of the non-Emergency Inpatient service.

      The Plan Administrator will respond to a Skilled Nursing Facility admission review request within 24 hours after its receipt. The Plan Administrator may request additional

information in order to determine whether to approve or disapprove benefits for an Inpatient service.

In this case, the Plan Administrator will respond with an approval or disapproval within 24 hours after the necessary information is supplied.

- If, as a part of the Skilled Nursing Facility admission review procedure the Plan Administrator determines that a contemplated Inpatient service is not Medically Necessary and the member elects to proceed with the Inpatient service despite this determination, the Plan Administrator will deny this service as not Medically Necessary unless additional information is provided indicating a contrary result is warranted. You are financially responsible for Skilled Nursing Facility services which are not Medically Necessary.

Special Limits

Days of Inpatient care	180 days per Stay[1]

Health Plan Reimbursement

Your Health Plan pays the Allowable Charge for services in a network Skilled Nursing Facility during approved admissions.

Member Pays

Refer to the Benefits Summary for the plan in which you are enrolled.

[1] A Stay is the period from the admission to the date of discharge from a Facility. If there is less than a 90 day break between two admissions, the days allowable for the subsequent admission are reduced by the days used in the first. If there are more than 90 days between the two admissions, the days available for the subsequent admission start over for a full 180 days.

HOME HEALTH SERVICES

Services Which Are Eligible for Reimbursement

1) Professional Medical services.

2) Periodic skilled nursing care for needs that can only be met by a Licensed Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) under the supervision of an R.N.

3) Therapy services.

4) Medical social services provided by a licensed clinical social worker or social services assistant under the guidance of a licensed clinical social worker.

5) Services eligible for coverage by a home health aide for personal care provided the member has a skilled need and the services are under the supervision of an R.N.

6) Nutritional guidance, but limited to individual consultation by an R.N. or qualified dietician.

7) Diagnostic tests, non-covered therapy services, and similar services which would be covered if you were an Inpatient in a hospital. These services are also covered when received in your Provider's office or the Outpatient department of a hospital, but the services must be arranged through the network home health care agency.

8) Ambulance services if prearranged by your physician and authorized by the Plan Administrator if, because of your Medical condition, you cannot ride safely in a car when you go to your Provider's office or to the Outpatient department of the hospital. Ambulance services will be covered if your condition suddenly becomes worse and you must go to a local hospital's Emergency room.

9) Supplies normally used in a hospital for an Inpatient, but these supplies must be dispensed by the network home health care agency.

10) Administration of drugs prescribed by your Provider.

Conditions for Reimbursement

1) Home Health Services must be medically skilled services provided in your home and:

   - prescribed by a Provider licensed to do so;
   - listed in your plan of treatment filed with the Plan Administrator;
   - furnished and billed by a network home health care agency;
   - services that the Plan Administrator approved for payment before services are rendered, and Medically Necessary.

2) You must be homebound for Medical reasons. You must be physically unable to obtain Medical care as an Outpatient. You will still be considered homebound for Medical reasons if you must go to the Outpatient department of the hospital because the services you need cannot be furnished in your home.

3) You must be under the active care of a Provider to be eligible for Home Health Services. Your Provider must certify to the Plan Administrator in writing that you would have to be admitted as an Inpatient to a hospital or Skilled Nursing Facility if Home Health Services were not available. Approval will be subject to review by the Plan Administrator for appropriateness in accordance with Medical policy.

4) Home Health Services will be provided after your discharge from a hospital as an Inpatient only when the Plan Administrator has received and approved your plan of treatment in advance.

5) If you are not first confined in a hospital, Home Health Services will be provided only when the Plan Administrator has received and approved your plan of treatment in advance.

6) Services must follow your plan of treatment. Your plan of treatment must be included in your Medical record. Your Medical record must be reviewed by your Provider at regular intervals. A copy of your plan of treatment must be filed with the Plan Administrator before Home Health Services can begin. Any changes to your plan of treatment must be approved for payment in advance by the Plan Administrator.

7) Services must be furnished by trained health care workers employed by the network home health care agency. A network home health care agency may make arrangements with another health care organization to provide you with a Home Health Service, but the Plan Administrator must approve any such arrangement with another health care organization in writing in advance.

8) The following rules apply only to Visits for Home Health Services:

   - when a health care worker comes to your home more than once a day to provide Home Health Services, each Visit will be counted as a separate Visit;
   - when two or more health care workers come to your home at the same time to provide a single service, the joint Visit will be counted as one Visit;
   - when two or more health care workers come to your home to provide different types of Home Health Services, the Visit of each health care worker will be counted as a separate Visit; and
   - when special Medical Equipment is needed that cannot be brought into your home, each time you leave home to use the equipment will be counted as a separate Visit.

9) Approval of a plan of treatment, or any part of a plan of treatment, or any arrangement with another health care organization means only that the Plan Administrator will later consider these services for payment. The Plan Administrator's approval is neither an endorsement of the quality of the service nor a waiver of any term or condition of this contract.

10) Disapproval of a plan of treatment, or any part of a plan of treatment, or any arrangement with another health care organization means only that the Plan Administrator has determined in advance the services are not covered under this section. Some private duty nursing services, Medical supplies, and Medical Equipment (durable) may be covered as separately listed under **Other Covered Services**. Please see the **Other Covered Services** section.

    You may still elect to receive any other services disapproved by the Plan Administrator, but these will be at your own expense.

11) Therapy services must be rendered by a therapist qualified to do so.

12) Your need for personal care must be determined by the R.N. working for the network home health care agency. The R.N. must assign duties to the home health aide. Personal care may include non-medically skilled services. The words "personal care" mean:

- helping you walk;
- helping you take a bath;
- helping you dress;
- giving you medicine; and
- teaching you self-help skills.

Special Limits

1) Visit maximum 90 Visits per Plan Year

2) Payment will not be made for:

- homemaker or housekeeping services;
- housing, food, home delivered meals, or "Meals on Wheels";
- services not listed in your attending Provider's plan of treatment, except for ambulance services to a hospital Emergency room;
- unlicensed counselor's services;
- services for or which are related to diversional, recreational, or social activities;
- prosthetic devices, appliances, and orthopedic braces; or
- convenience services or supplies that could be taken care of by the family (like simple dressing changes or a bedside table).

Health Plan Reimbursement

Your Health Plan pays the Allowable Charge.

Member Pays

There is no Copayment, Deductible or Coinsurance for services billed as Home Health Services.

Other services billed in conjunction with Home Health Services are subject to the applicable Copayment, Deductible or Coinsurance.

Refer to the Benefits Summary for the plan in which you are enrolled.

PROFESSIONAL SERVICES

MEDICAL, SURGICAL, AND BEHAVIORAL HEALTH SERVICES

This section explains which Medical, surgical, and Behavioral Health services from health professionals may be eligible for Reimbursement. In general, the professional services of authorized Providers are eligible for Reimbursement if they are Medically Necessary and rendered within the scope of the Provider's license.

Services Which Are Eligible for Reimbursement

1) Inpatient Medical, surgical, and Behavioral Health services. These services are specifically included:

   - surgical services;
   - reconstructive surgery to restore a body function, correct congenital or developmental deformity which causes functional impairment, or relieve pain;
   - operative procedures for sterilization or to reverse a sterile condition;
   - multiple surgeries;
   - assistant surgeon's services;
   - maternity services rendered during an Inpatient Stay:
     - routine delivery services (cesarean birth is a surgical service);
     - anesthesia services to provide complete or partial loss of sensation before delivery;
     - services for complications of pregnancy;
     - services for miscarriage; and
     - services for the care of a newborn child if the child is enrolled as an eligible dependent for the time the services are rendered such as:
       - initial examination of a newborn and circumcision of a covered male dependent
       - hospital services for non-routine nursery care for the newborn should complications arise that require the newborn to be admitted
   - anesthesia services rendered by a second physician;
   - Medical and Behavioral Health Visits by a Provider, including:
     - intensive Medical services (when your Medical condition requires a Provider's constant attendance and treatment for a prolonged period of time);
     - concurrent care (treatment you receive from a Provider other than the operating surgeon for a Medical condition separate from the condition for which you required surgery);
     - Behavioral Health evaluative and concurrent services; and
     - consultative services from a Provider other than the attending Provider.

2) Outpatient Medical, surgical, and Behavioral Health services, including:

   - office Visits;
   - surgical services;
   - LiveHealth Online;
   - Telemedicine;
   - maternity services including Visits to a Provider for routine pre- and postnatal care;
   - delivery of a newborn at home by a Provider;
   - anesthesia services;

- fetal screenings, which are tests for the genetic and/or chromosomal status of the fetus. The term also means anatomical, biochemical or biophysical tests to better define the likelihood of genetic and/or chromosomal anomalies;
- Medical services to diagnose or treat your illness or injury;
- diagnostic tests, labs and x-rays;
- therapy services;
- Shots;
- diabetes Outpatient self-management training and education performed in person, including Medical nutrition therapy when provided by a certified, licensed, or registered health care professional. These services are only covered when billed by a Medical Provider or the Outpatient department of a hospital. Diabetic education is covered at no cost to you;
- a Medical or surgical service if performed by a Provider's employee who is licensed to perform the service; and
- prescription medications that require administration by a health professional including contraceptive devices and injections.

3) Treatment of morbid obesity

Your Health Plan may cover treatment of morbid obesity through gastric bypass, or other methods recognized by the National Institutes of Health (NIH). According to the NIH guidelines, gastric bypass surgery is effective for the long-term reversal of morbid obesity for a patient who:

- weighs at least 100 pounds over or twice the ideal body weight for frame, age, height and gender as specified in the 1983 Metropolitan Life Insurance tables;
- has a body mass index equal to or greater than 35 kilograms per meter squared, with comorbidity or coexisting Medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes; or
- has a body mass index of 40 kilograms per meter squared, without such comorbidity.

As used above, body mass index equals weight in kilograms divided by height in meters squared.

<u>Pre-Surgery Procedures</u>
If you are seeking bariatric surgery for the first time or as a revision to a prior surgery, you are required to participate in a 6 month continuous non-surgical weight reduction program. The goal of this program is to help bariatric surgery candidates break through personal barriers to achieve safe and effective long-term weight loss. The program must be documented by the Provider requesting authorization for the surgery.

Getting started:
- Your bariatric surgeon must contact Anthem to request a Health Services Review for your surgery.

After completing the program:
You, your surgeon and an Anthem case manager will determine if bariatric surgery is the best option for you and whether it may be approved under the surgery guidelines.

Bariatric surgery must be performed within 24 months of completing the non-surgical weight reduction program.

Post weight loss procedures
Your Health Plan may also cover some services (such as abdominoplasties, panniculectomies, and lipectomies) to correct deformity after a previous therapeutic process involving gastric bypass surgery, other bariatric surgery procedures, or other methods of weight loss.

In order to be covered, a service must be Medically Necessary. Before rendering any of these services, your Provider should contact the Plan Administrator and request a Health Services Review. Ultimately, it is your responsibility to ensure that the service is authorized for Medical Necessity.

If a Health Services Review is not obtained and the services are retrospectively denied, you are responsible for payment of non-covered service(s).

Conditions for Reimbursement

1) Medical, surgical, and Behavioral Health services must be:

   - medically skilled services;
   - billed for by a Provider in private practice;
   - services which the Provider is licensed to render; and
   - Medically Necessary.

2) A Health Services Review, which is performed by AIM Specialty Health (AIM) on behalf of Anthem, is required for sleep studies.

   This list of services is only a sampling and may change, so always check with your Provider or Plan Administrator's Member Services for the most current and complete list. While there is no penalty if the pre-service is not performed in advance of receiving the service, the advantage of the pre-service review is that you and your Provider know beforehand whether the service is appropriate, Medically Necessary, and meets coverage guidelines. If advance approval is not obtained, payment of the claim may be delayed. Also, if the service is later determined not to be Medically Necessary, you may have to pay for the service.

3) When two or more surgical services are performed during a single operative session, the Allowable Charge for the combined services will be calculated as follows:

   - the Allowable Charge for the primary, or major, surgical service performed; plus
   - a reduced percentage of what the Allowable Charge would have been for each additional surgical service if these services had been performed alone.

4) Assistant surgeon's services are covered if the operating surgeon explains to the Plan Administrator, upon request, why this surgical service requires the skills of two surgeons. When two or more surgeons provide a surgical service which could reasonably have been performed by one surgeon, the Allowable Charge for this surgical service will not exceed the Allowable Charge available to one surgeon.

5) Inpatient consultative services are covered provided that the services are requested by your attending Provider. The Provider rendering the consultative services must examine you and must enter a signed consultation note in your Medical record.

6) If you are admitted to the hospital for an Emergency, you, your Provider, or someone you authorize should contact the Plan Administrator within 48 hours or, if later, the next business day.

7) For maternity care, if your physician submits one bill for delivery, prenatal, and postnatal care services (global billing), payment will be made at the same level as Inpatient professional Provider services. Services for diagnostic tests, labs and X-rays are not part of the global maternity billing and are therefore considered under Your Health Plan benefits for those services.

   If your physician bills for delivery, prenatal and postnatal care services separately (non-global billing) or if you change Providers during the course of your maternity care, your payment responsibility will be determined by the services received.

8) It is recommended, especially for high cost services, that you have your Provider call the Plan Administrator to determine if the service is covered in advance of receiving services, and it is your obligation to check with your Provider to make sure the review has been done. You can also request a voluntary Health Services Review directly with the Plan Administrator. **If you sign a financial waiver from the Provider or hospital then you may be responsible for services not covered by Your Health Plan.**

Special Limits

1) For maternity, you must add your newborn to Your Health Plan within the timeframe allowed by the group's flexible benefits document and no more than 60 days of the date of birth.

2) Inpatient professional services in a Skilled Nursing Facility are limited to 180 days per Stay.

3) If a Visit is part of a Home Health Services program, it will reduce by one the maximum number of Visits available for Home Health Services.

4) If you receive Inpatient or Outpatient services that are denied as not Medically Necessary, certain professional Provider services that you receive during your Inpatient Stay or as part of your Outpatient services will not be denied under this Exclusion in spite of the Medical necessity denial of the overall services:

   For Inpatients
   a) Services that are rendered by professional Providers who do not control whether you are treated on an Inpatient basis, such as pathologists, radiologists, anesthesiologists, and consulting physicians.

   b) Services rendered by your attending Provider other than Inpatient evaluation and management services provided to you. Inpatient evaluation and management services include routine Visits by your admitting or attending Provider for purposes such as reviewing patient status, test results, and patient Medical records. Inpatient evaluation and management Visits do not include surgical, diagnostic, or therapeutic services performed by your admitting or attending Provider.

   For Outpatients
   a) Services of pathologists, radiologists and anesthesiologists rendering services in an (i) Outpatient hospital Setting, (ii) Emergency room, or (iii) ambulatory surgery Setting.

However, this exception does not apply if and when any such pathologist, radiologist or anesthesiologist assumes the role of attending physician.

5) If during the course of one Visit, multiple types of service are received where those types of service carry separate benefit Copayments/Coinsurance (e.g., physical therapy and a spinal manipulation), the services will be subject to the higher Copayment.

Health Plan Reimbursement

Your Health Plan pays the remaining Allowable Charge after your Deductible, Copayment or Coinsurance.

Separate benefits will not be provided for routine pre- and post-operative care. The Plan Administrator takes these services into account when determining its Allowable Charge for a surgical service.

When the same physician performs both the surgical or maternity service and the anesthesia service, the Allowable Charge for the anesthesia service will be 50% of what the Allowable Charge would have been if a second physician had performed the anesthesia service.

Member Pays

Refer to the Benefits Summary for the plan in which you are enrolled.

BEHAVIORAL HEALTH SERVICES AND EMPLOYEE ASSISTANCE PROGRAM (EAP)

Services Which Are Eligible for Reimbursement

Behavioral Health Services

1) Eligible Behavioral Health services are covered if Medically Necessary. Services for alcohol and substance abuse may be reimbursable when rendered in an Outpatient Setting such as an Intensive Outpatient Treatment Program.

2) Partial Day Hospitalization when rendered in an Outpatient Setting.

3) Detoxification may be reimbursable when rendered in an Inpatient Setting.

4) Residential Treatment may be reimbursable when rendered in an Inpatient Setting. Services provided for Residential Treatment include but are not limited to the following:

   - multi-disciplinary evaluation;
   - medication management;
   - individual, family and group therapy;
   - parental guidance; and
   - substance abuse education/counseling.

5) Residential Treatment Centers must include room, board and skilled nursing care (either an RN or LVN/LPN) available on-site at least eight hours daily with 24-hour availability.

6) Intensive Outpatient Treatment
   Intensive Outpatient Programs (IOP) must:

   - meet at least three times per week;
   - provide a minimum of three (3) hours of treatment per session; and
   - be supervised by a licensed mental health professional.

7) Telemedicine

8) Certain treatments associated with autism spectrum disorder (ASD) for dependents from age 2 through age 10. Coverage for ASD includes but is not limited to the following:

   - diagnosis and treatment of ASD;
   - pharmacy care;
   - psychiatric care;
   - psychological care;
   - therapeutic care; and
   - Applied Behavior Analysis (ABA)

Employee Assistance Program (EAP)

1) The Employee Assistance Program (EAP) is a free, voluntary, confidential service to help you, covered dependents and members of your household deal with personal challenges that can be addressed through short-term counseling.

2) The EAP provides up to four counseling sessions per issue per Plan Year, free of charge for you, covered dependents and members of your household. Access to care starts with a phone call to Anthem EAP at **855-223-9277**. Counselors are available to take your call 24 hours a day, seven days a week, to help you address a variety of issues including:

   - relationship or family issues
   - depression and anxiety
   - stress management
   - work issues
   - alcohol or drug abuse
   - daily life challenges

   After assessing your situation, a counselor will recommend whether your care should be provided through the EAP and/or referred to Behavioral Health.

   The EAP can help you locate child and adult care resources. You can also call the EAP for guidance on a number of legal and financial issues, including divorce, domestic violence, estate planning and family budgeting. If you need additional legal or financial assistance, the EAP counselor will refer you to a carefully screened attorney or financial counselor in your community.

3) All services through Anthem EAP are voluntary and confidential in accordance with state and federal laws. Anthem EAP will not disclose information to anyone without your explicit written authorization, except within federal and state guidelines for release of confidential information.

Conditions for Reimbursement

1) You are encouraged to have all Behavioral Health services Precertified by calling Anthem Behavioral Health at **855-223-9277** before receiving care, or within 48 hours of an Emergency admission. This includes all Inpatient, Residential Treatment, Intensive Outpatient Treatment (IOP), Partial Hospitalization, and Outpatient Behavioral Health Services. While Precertification is not required, it does ensure that you are using a participating Provider and that services are covered and Medically Necessary. If services are not considered Medically Necessary to treat a condition, or if you use a non-Anthem participating Provider, benefits will not be payable.

2) When you receive care from a Provider to whom you have been referred by Anthem Behavioral Health, the Provider works with an Anthem Behavioral Health Care manager to ensure that the services you receive are covered under Your Health Plan. Professional staff members are available 24 hours a day, every day, to answer questions, assist with referrals to participating Providers, and precertify care. When you do not obtain Precertification, you are responsible for making sure that the services you receive are Medically Necessary for your condition.

3) In the event of a Behavioral Health or substance abuse crisis, Behavioral Health professionals are available at all times to assist you and to connect you to the appropriate local resources to ensure that your situation is managed safely.

4) Applied Behavior Analysis (ABA) services for the treatment of a member diagnosed with autism spectrum disorder (ASD) must be defined in a treatment plan from a licensed physician or a licensed psychologist who determines the care to be Medically Necessary. In

addition, the service must be provided or supervised by a board certified behavior analyst who is licensed by the Board of Medicine. Per the Board of Medicine licensing regulations for ABA Providers, unlicensed paraprofessionals may provide services related to ABA, but the services they provide must not constitute ABA. The prescribing practitioner shall be independent of the Provider of Applied Behavior Analysis.

5) Residential Treatment Centers must be licensed and operated as required by law, and include:

- a staff with one or more doctors available at all times;
- Residential Treatment takes place in a structured facility-based Setting;
- the resources and programming to adequately diagnose, care and treat a psychiatric and/or substance use disorder; and
- facilities are designated residential, subacute, or intermediate care and may occur in care systems that provide multiple levels of care.

Special Limits

1) The Employee Assistance Program provides up to four Visits per issue per Plan Year for you, covered dependents and members of your household.

2) Applied Behavior Analysis services for autism spectrum disorder are covered for children ages 2 through 10.

3) Key Advantage Expanded and Key Advantage 250 ONLY - For Behavioral Health treatment rendered in one Level of Care (Inpatient, Residential Treatment, Partial Day Hospitalization, Intensive Outpatient Treatment) within 15 days of Behavioral Health treatment rendered in a different Level of Care, the second Copayment will be waived (ex. move from Inpatient to Partial Day Hospitalization or move from Intensive Outpatient Treatment to Inpatient).

Health Plan Reimbursement

Your Health Plan pays the remaining Allowable Charge after your Deductible, Copayment or Coinsurance for covered services in a network hospital during approved admissions.

Member Pays

Refer to the Benefits Summary for the plan in which you are enrolled.

CHIROPRACTIC, SPINAL MANIPULATION AND OTHER MANUAL MEDICAL INTERVENTION SERVICES

Services Which Are Eligible for Reimbursement

Spinal manipulations and other manual Medical interventions and associated evaluation and management services, including manipulation of the spine and other joints, application of manual traction and soft tissue manipulations are eligible for Reimbursement. These services are most commonly performed by a chiropractor, general practitioner, physical therapist or osteopath.

Conditions for Reimbursement

Services must be:

- performed by a licensed chiropractor or licensed Medical Provider;
- billed for by a chiropractor in private practice or a Provider;
- those which the Provider is licensed to render; and
- Medically Necessary.

Special Limits

1) Reimbursement is limited to 30 Visits per Plan Year per member.

2) If during the course of one Visit, multiple types of service are received where those types of service carry separate benefit Copayments/Coinsurance (e.g., physical therapy and a spinal manipulation), the services will be subject to the higher Copayment/Coinsurance.

Health Plan Reimbursement

Your Health Plan pays the remaining Allowable Charge after your Copayment.

Member Pays

Refer to the Benefits Summary for the plan in which you are enrolled.

WELLNESS AND PREVENTIVE CARE SERVICES

Services Which Are Eligible for Reimbursement

Child Wellness and Preventive Care

1) The following wellness and preventive care screening services are covered:

- Behavioral counseling to promote a healthy diet
- Blood pressure
- Cholesterol and lipid level screening
- Developmental and behavioral assessments
- Hearing screening
- Height, weight and body mass index (BMI)
- Hemoglobin or hematocrit (blood count)
- Newborn screenings
- Oral health assessment
- Pelvic exam and Pap test, including screening for cervical cancer
- Screening and counseling for obesity
- Screening for depression
- Screening for lead exposure
- Screening for sexually transmitted infections
- Vision screenings

2) The following wellness and preventive care immunizations are covered:

- Diphtheria, Tetanus, Pertussis (DTaP)
- Haemophilus Influenza type b (Hib)
- Hepatitis A
- Hepatitis B
- Human Papillomavirus (HPV)
- Influenza (flu)
- Measles, Mumps, Rubella (MMR)
- Meningococcal (meningitis)
- Pneumococcal (pneumonia)
- Polio
- Rotavirus
- Varicella (chicken pox)

The following immunization schedule is recommended for children from birth through 6 years old by the U.S. Department of Health and Human Services Centers for Disease Control and Prevention in partnership with the American Academy of Family Physicians and the American Academy of Pediatrics:

• Birth	• 4 months	• 15 months	• 3 years
• 3-5 days	• 6 months	• 18 months	• 4 years
• 2-4 weeks	• 9 months	• 24 months	• 5 years
• 2 months	• 12 months	• 30 months	• 6 years

Follow your Pediatrician's recommendation for well child and immunization Visits.

The following generic prescription strength over-the-counter (OTC) products are covered, and require a prescription from a Provider:

- Iron supplements for children 6-12 months
- Fluoride supplements for children from birth through 6 years old

Adult Wellness and Preventive Care

The following wellness and preventive care screening and services are covered:

- Annual wellness check-up
- Aortic aneurysm screening
- Blood pressure
- Bone density test to screen for osteoporosis
- Breastfeeding support, supplies and counseling
- Cholesterol and lipid level screening
- Colorectal cancer screening, including
- one fecal occult blood test; and
- one flexible sigmoidoscopy, or colonoscopy or double contrast barium enema
- Contraceptive counseling and sterilization procedures
- Diabetes screening
- Eye chart vision screening
- Generic, single-source brand and multi-source brand FDA-approved contraceptives and FDA-approved women's over-the-counter (OTC) contraceptives (female condoms, spermicides) all requiring a prescription from a Provider
- Prescription medications, such as Tamoxifen or Raloxifene, for women who are at increased risk for breast cancer as recommended by the United States Preventive Services Task Force (USPSTF-B recommendation). A prescription from a Provider and prior authorization are required.
- Gynecological examination
- Hearing screening
- Height, weight and BMI
- Mammography screening
- Pap test
- Prostate exam (digital rectal exam)
- Prostate specific antigen test (PSA)
- Screening and counseling for interpersonal and domestic violence
- Screening and counseling for sexually transmitted infections – including human immunodeficiency virus (HIV)
- Screening for depression
- Screening for gestational diabetes for women 24 to 28 weeks pregnant, and at high risk of developing gestational diabetes
- Screenings during pregnancy
- including but not limited to, hepatitis, asymptomatic bacteriuria, Rh incompatibility, syphilis, iron deficiency anemia, gonorrhea, chlamydia and HIV
- Testing for human papillomavirus (HPV)

The following wellness and preventive intervention services (includes counseling and education) are covered:

- Screening and counseling for obesity
- Genetic counseling with a family history of breast and/or ovarian cancer
- Behavioral counseling to promote a healthy diet
- Counseling related to aspirin use, folic acid and iron, for the prevention of cardiovascular disease
- Screening and behavioral counseling related to tobacco use
- Screening and behavioral counseling related to alcohol misuse

The following generic prescription strength over-the-counter (OTC) products are covered, and require a prescription from a Provider:

- Aspirin (81mg and 325mg) for men between ages 45-79 and women between ages 55-79
- Low-dose aspirin (81mg) for pregnant women who are at increased risk of preeclampsia
- Bowel Preps between ages 49-76 (two script limit per 365 days)
- Folic acid (.4mg-.8mg) for women through age 55
- Vitamin D (vitamin D2 or D3 containing 1,000 IU or less per dosage form) for women 65 and over

The following wellness and preventive immunizations are covered:

- Hepatitis A
- Hepatitis B
- Human Papillomavirus (HPV)
- Influenza (flu)
- Measles, Mumps, Rubella (MMR)
- Meningococcal (meningitis)
- Pneumococcal (pneumonia)
- Tetanus, Diphtheria, Pertussis (Tdap)
- Varicella (chicken pox)
- Zostavax (shingles)

The following FDA-approved smoking cessation prescription drugs and certain generic over-the-counter (OTC) nicotine replacement products are covered, and require a prescription from a Provider:

- Chantix
- buproban 150mg
- burpropion SR 150mg (generic Zyban)
- Nicotine gum (except brand Nicorette)
- Nicotine lozenges (except brand Commit)
- Nicotine patch (except brands Habitrol & Nicoderm)

Conditions for Reimbursement

1) Services must be:
    - billed for by a Provider in private practice;
    - services which the Provider is licensed to render; and
    - deemed age appropriate by the Provider.

2) Wellness immunizations must be received in the Provider's office or at a participating Outpatient pharmacy. Routine immunizations are not covered in an Outpatient hospital Setting.

3) Colorectal cancer screenings are covered in the Provider's office or Outpatient hospital Setting.

4) To receive 100% coverage for the generic prescription strength over-the-counter (OTC) products listed under Services Which Are Eligible for Reimbursement, services must be purchased at an in-network pharmacy with a prescription from a Provider.

5) To receive 100% coverage for covered contraceptives (including OTC contraceptives), services must be:

- a generic drug or a single-source brand name drug that does not have a generic equivalent (single source);
- multi-source brand name drug when deemed Medically Necessary;
- prescribed by a Provider; and
- must be filled at an in-network pharmacy.

Special Limits

1) Preventive services are limited to one each per Plan Year.

2) Preventive services are not recommended for all individuals and appropriateness may be determined by the treating Provider and recommendation guidelines.

3) A routine preventive screening may identify abnormalities or problems that require immediate intervention or additional diagnosis. If this occurs, and your Provider performs additional necessary covered services, these services will generally be covered as diagnostic and/or surgical services and not as preventive care services unless this is the first preventive screening of the Plan Year. As such, they may be subject to a Copayment and/or Coinsurance. You are entitled to routine preventive benefits even if you have an existing Medical condition or if you have a family history of a Medical condition.

4) Immunizations, laboratory and x-ray services that are completed within five calendar days before or after the annual wellness check-up Visit will be covered at 100%. It is your responsibility to inform the Provider when the purpose of your Visit is for the annual wellness check-up.

5) A cost-share may apply for prescription contraceptives other than generic or single source brand name. To be covered at 100%, multi-source brand contraceptives must be Medically Necessary as prescribed by a Provider and requires prior-authorization.

6) Benefits for breast pumps are limited to one pump per pregnancy. You may purchase or rent a breast pump from an in-network hospital, doctor or durable Medical company. Breast pumps are not covered if purchased through retail stores or an Outpatient pharmacy.

7) Coverage for smoking cessation prescription drugs and over-the-counter nicotine replacement products are limited to 180 days of therapy per rolling 365 days. A Copayment will apply to services that exceed plan limits.

Health Plan Reimbursement

Your Health Plan pays the Allowable Charge.

Member Pays

No Copayment, Deductible or Coinsurance.

Refer to the Benefits Summary for the plan in which you are enrolled.

THERAPY SERVICES

Services Which Are Eligible for Reimbursement[1]

1) Cardiac rehabilitation, which is the process of restoring and maintaining the physiological, psychological, social and vocational capabilities of patients with heart disease.

2) Chemotherapy for the treatment of disease by chemical or biological antineoplastic agents.

3) Infusion therapy (IV therapy), which is treatment by placing therapeutic agents into the vein, and parenteral administration of medication and nutrients. Infusion services also include enteral nutrition, which is the delivery of nutrients by tube into the gastrointestinal tract. These services include coverage of all medications administered intravenously and/or parenterally.

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

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

6) Radiation therapy, including the rental or cost of radioactive materials. It covers the treatment of disease by x-ray, radium, cobalt, or high energy particle sources.

7) Respiratory therapy, which is the introduction of dry or moist gases into the lungs to treat illness or injury.

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

Conditions for Reimbursement

1) Your Health Plan covers therapy services when the treatment is Medically Necessary for your condition and provided by a licensed Provider.

2) A Health Services Review, which is performed by AIM Specialty Health (AIM) on behalf of Anthem, is conducted for chemotherapy and radiation therapy. The oncology Health Services Review through AIM reviews quality protocols and clinical guidelines with the Provider, as necessary.

   This list of services is only a sampling and may change, so always check with your Provider or Plan Administrator's Member Services for the most current and complete list. While there is no penalty if the pre-service is not performed in advance of receiving the service, the advantage of the pre-service review is that you and your Provider know beforehand whether the service is appropriate, Medically Necessary, and meets coverage guidelines. If advance approval is not obtained, payment of the claim may be delayed. Also, if the service is later determined not to be Medically Necessary, you may have to pay for the service.

Special Limits

If during the course of one Visit, multiple types of service are received where those types of service carry separate benefit Copayments/Coinsurance (e.g., physical therapy and a spinal manipulation), the services will be subject to the higher Copayment.

Health Plan Reimbursement

Your Health Plan pays the remaining Allowable Charge after your Deductible or Coinsurance.

Member Pays

Refer to the Benefits Summary for the plan in which you are enrolled.

[1] Chiropractic, Spinal Manipulation and Other Manual Medical Intervention Services have a Plan Year Visit limit. This benefit is defined in its own section of this booklet.

EARLY INTERVENTION SERVICES

Services Which Are Eligible for Reimbursement

Early intervention services are for covered dependents from birth to age three who are certified by the Department of Behavioral Health and Developmental Services (DBHDS) as eligible for services under Part C of the Individuals with Disabilities Education Act (IDEA). You are responsible for contacting your local DBHDS agency to initiate certification.

These services consist of:

- assistive technology services and devices (for example, hearing aids, glasses and durable Medical Equipment);
- occupational therapy;
- physical therapy; and
- speech and language therapy.

Conditions for Reimbursement

1) Early intervention services for the population certified by DBHDS are those services listed above which are determined to be Medically Necessary by DBHDS and designed to help an individual attain or retain the capability to function age-appropriately within his environment.

2) This includes services which enhance functional ability without effecting a cure. Benefits for services listed will not be limited by the Exclusion of services that are not Medically Necessary.

Special Limits

Physical therapy, occupational therapy, or speech therapy to maintain or preserve current functions if there is no chance of improvement or reversal is only available for children under age 3 who qualify for early intervention services.

Health Plan Reimbursement

Your Health Plan pays the remaining Allowable Charge after your Deductible, Copayment or Coinsurance.

Member Pays

Early intervention services determined by service received	Deductible/Copayment/Coinsurance

HOSPICE CARE SERVICES

Services Which Are Eligible for Reimbursement

1) Hospice care services are available if you are diagnosed with a terminal illness with a life expectancy of six months or fewer.

2) Hospice care services include a program of home and Inpatient care provided directly by or under the direction of a licensed hospice.

3) Hospice care programs include palliative care and supportive physician, psychological, psychosocial, and other health services to individuals utilizing a medically directed interdisciplinary team.

Conditions for Reimbursement

Hospice care services must be:

- prescribed by a Provider licensed to do so;
- furnished and billed by a licensed hospice; and
- Medically Necessary.

Special Limits

None.

Health Plan Reimbursement

Your Health Plan pays the Allowable Charge.

Member Pays

No Copayment, Deductible or Coinsurance.

Refer to the Benefits Summary for the plan in which you are enrolled.

OTHER COVERED SERVICES

Services Which Are Eligible for Reimbursement

1) Professional ambulance services to or from the nearest Facility or Provider adequate to treat your condition. Air ambulance services are also covered when precertified or in cases of threatened loss of life. In determining whether any ambulance services will be precertified, the Plan Administrator will take into account whether appropriate, cost-effective care is being provided at the Facility where the Covered Person is located.

2) Medical supplies are covered if they are prescribed by a covered Provider. Examples of Medical supplies are oxygen and equipment (respirators). Some Medical supplies require Health Services Review. Contact Anthem Member Services at **800-552-2682.**

3) The cost of fitting, adjustment, and repair of the following items when prescribed by your doctor for Activities of Daily Living:

   - arm braces, back braces and neck braces;
   - artificial limbs, including accessories;
   - breast prostheses;
   - catheters and related supplies;
   - head halters;
   - leg braces, including attached or built-up shoes attached to the leg brace;
   - orthopedic braces;
   - orthotics, other than foot orthotics;
   - splints; and
   - wigs.

4) The rental (or purchase if that would be less expensive) of Medical Equipment (durable) when prescribed by your doctor requires Health Services Review. Contact Anthem Member Services at **800-552-2682** for assistance with Health Services Review. Coverage specific guidelines for sleep therapy equipment and related supplies are found later in this section.

   Also covered are maintenance and necessary repairs of Medical Equipment (durable) except when damage is due to neglect. Network Medical Equipment (durable) Providers are shown in the Anthem Commonwealth of Virginia and The Local Choice Medical Provider Directory under Ancillaries, Durable Medical Equipment. If you obtain equipment from a non-network Medical Equipment (durable) Provider, you will still have coverage. However, in addition to your Deductible and Coinsurance, the non-network Provider may bill you for the difference between the Allowable Charge and the Provider's charge (Balance Bill).

   Coverage includes equipment such as:

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

In addition, rental of Medical Equipment (durable) will be provided for a limited time for a condition for which you received covered services before your coverage ended. The time will be the shorter of when you become covered under any other group coverage, or the end of the Plan Year your coverage ends, or a period equal to the time you were enrolled under Your Health Plan.

5) Special Medical formulas which are the primary source of nutrition for Covered Persons with inborn errors of amino acid or organic acid metabolism, metabolic abnormality or severe protein or soy allergies. These formulas must be prescribed by a physician and required to maintain adequate nutritional status.

6) Covered diabetic equipment includes:

   - insulin pumps and associated supplies;
   - lancet devices; and
   - calibrator solution.

   See the **Outpatient Prescription Drug** section for other covered diabetic supplies.

7) Home private duty nursing services when the medically skilled services are provided by a Licensed Registered Nurse (RN) or Licensed Practical Nurse (LPN) in your home and the nurse is not a relative or member of your family. Your doctor must certify to Anthem that private duty nursing services are Medically Necessary for your condition, and not merely custodial in nature.

8) The following prescribed eyeglasses or contact lenses only when required as a result of surgery or for treatment of accidental injury:

   a. eyeglasses or contact lenses which replace human lenses lost as the result of intra-ocular surgery or accidental injury to the eye;
   b. "Pinhole" glasses used after surgery for a detached retina; or
   c. lenses used instead of surgery, such as:
      - contact lenses for the treatment of infantile glaucoma;
      - corneal or sceleral lenses in connection with keratoconus;
      - sceleral lenses to retain moisture when normal tearing is not possible or is not adequate; or
      - corneal or sceleral lenses to reduce a corneal irregularity (other than astigmatism).

   A maximum of one set of eyeglasses or one set of contact lenses will be covered for your original prescription or for any change in your original prescription. Examination and replacement for a prescription change are covered only when the change is due to the condition for which you needed the original prescription.

   See the **Routine Vision** section for information on routine vision coverage.

Conditions for Reimbursement

1) With respect to private duty nursing services, only services by a Licensed Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.) are covered. Also,

   - these services must be Medically Necessary;
   - the nurse may not be a relative or member of your family;
   - your Provider must explain why the services are required; and
   - your Provider must describe the medically skilled service provided.

2) For Medical Equipment (durable), your Provider must, upon request, explain why the equipment is needed and how long it will be used.

3) For coverage of ambulance services:

   - The trip to the Facility or Provider's office must be to the nearest one recognized by the Plan Administrator as having services adequate to treat your condition.
   - The services you receive in that Facility or Provider's office must be covered services.
   - If the Plan Administrator requests it, the attending Provider must explain why you could not have been transported in a private car or by any other less expensive means.
   - Ambulance services billed through the Facility are covered the same as all other Facility services.

4) For coverage of sleep therapy equipment and related supplies:

   - These services require a Health Services Review for Medical necessity.
   - A sleep study must have been performed within the past 12 months of the initial rental of sleep therapy equipment and supplies.
   - Sleep therapy equipment requires an initial 10-month rental with compliance review every 90 days. Once the equipment has been rented for 10 months, it is considered purchased.
   - Compliance for sleep therapy equipment is defined as greater than or equal to four hours of use per night on 70 percent of nights during a consecutive 30-day period.
   - Members who own their sleep therapy equipment must obtain authorization for related supplies and provide proof of compliance annually.
   - Replacement machine/equipment for broken non-repairable devices does not require a sleep study. Precertification is required.

5) The Other Covered Services discussed in this section are not eligible for Reimbursement if the same service is available under some other section of this booklet. The Plan Administrator will pay only once for a service and will not increase or extend benefits available under other sections of this booklet.

Special Limits

1) Prescribed services eligible for coverage may be subject to Medical policy limits, for example, wigs and prostheses. Always check with your Plan Administrator in advance of receiving services.

2) The following and similar items are not eligible for Reimbursement as Medical Equipment (durable):

- adjustments made to a vehicle;
- air conditioners;
- blood pressure cuffs;
- dehumidifiers and humidifiers;
- elevators;
- exercise equipment;
- handrails;
- ramps;
- telephones; or
- whirlpool baths.

3) Your Health Plan will not pay for any equipment which has both a non-therapeutic and therapeutic use. Your Health Plan will pay for the least expensive item of equipment required by your Medical condition. If Your Health Plan determines that purchase of the Medical Equipment (durable) is less expensive than rental, or if the equipment cannot be rented, Your Health Plan may approve the purchase as a covered service.

Health Plan Reimbursement

Your Health Plan pays the remaining Allowable Charge after your Deductible and Coinsurance.

Member Pays

Refer to the Benefits Summary for the plan in which you are enrolled.

OUTPATIENT PRESCRIPTION DRUGS (Mandatory Generic Program)

Services Which Are Eligible for Reimbursement

1) The drugs must:

   - by federal or state law, require a prescription order to be dispensed;
   - be approved for general use by the U. S. Food and Drug Administration (FDA);
   - be prescribed by a Provider licensed to do so;
   - be furnished and billed by a pharmacy for Outpatient use; and
   - be Medically Necessary.

2) Outpatient Prescription Drugs received through a retail pharmacy or Anthem's Home Delivery or Specialty Pharmacy Service (provided through Express Scripts Incorporated and Accredo Specialty Pharmacy).

3) Outpatient Prescription Drugs and devices approved by the FDA, including contraceptives and certain prescription smoking cessation drugs. Contact Anthem Member Services for detailed coverage information.

4) The following items for the treatment of diabetes:

   - blood glucose meters;
   - blood glucose test strips;
   - hypodermic needles and syringes;
   - insulin; and
   - lancets.

Anthem's Home Delivery Pharmacy Service

You may also purchase covered Maintenance Medications through the mail from Anthem's Home Delivery Pharmacy network, and your prescription will be delivered directly to your home. To receive your prescription by mail, follow these steps:

You can place your first order by phone or online at **www.anthem.com**.

By phone: Call **800-355-8279**. A representative will help you with your order. Have your prescription, doctor's name, phone number, drug name and strength, and credit card handy when you call.

Online: Login to **www.anthem.com** and select Pharmacy under the Benefits tab. Follow the steps under Pharmacy Self Service to request a new prescription or refill a current prescription.

You will receive your prescription drugs via first class mail or UPS approximately 14 days from the date you sent your order.

Accredo Specialty Pharmacy Service

Accredo Specialty Pharmacy provides you with personal counseling from nurses, registered pharmacists and patient care representatives who are trained in specialty medications. Specialty medications include drugs such as Procrit® to treat anemia, Copaxone® for multiple sclerosis and Enbrel® or Remicade® for rheumatoid arthritis and many other medications. The program includes 24-hour access to an Accredo Specialty Pharmacy pharmacist and free supplies needed to administer your medicine, such as needles and syringes.

Specialty Drugs are those covered drugs that typically have a higher cost and one or more of the following characteristics:

- complex therapy for complex disease;
- specialized patient training and coordination of care (services, supplies, or devices);
- required prior to therapy initiation and/or during therapy;
- unique patient compliance and safety monitoring requirements;
- unique requirements for handling, shipping and storage; and
- potential for significant waste due to the high cost of the drug.

Exceptions to the price threshold may exist based on certain characteristics of the drug or therapy which will still require the drug to be classified as a Specialty Drug. Some examples of the disease categories currently in Accredo Specialty Pharmacy programs include cancer, cystic fibrosis, Gaucher disease, growth hormone deficiency, hemophilia, immune deficiency, Hepatitis C, multiple sclerosis, rheumatoid arthritis and RSV prophylaxis.

In addition, a follow-on biologic or generic product will be considered a Specialty Drug if the innovator drug is a Specialty Drug.

Call toll-free **877-886-1705** to order your specialty medication. Or if you prefer, your Provider may call the Accredo Specialty Pharmacy directly at **800-987-4904**. More information is available at **www.anthem.com/tlc**.

Prescription Drug Refills When Traveling

If you are planning to travel on vacation or leaving home for an extended period, you may need one or more early refills of your medication. Participating retail pharmacies and the Anthem Home Delivery Pharmacy Service may routinely provide one early refill (up to a 34-day or a 90-day supply, as appropriate) to accommodate travel. However, for extended travel, members should complete the Prescription Drug Refill Exception Request form available on the DHRM website at **www.thelocalchoice.virginia.gov** or from your Benefits Administrator. Send the completed form by fax or U.S. Mail to:

The Department of Human Resource Management (DHRM)
Office of Health Benefits
Attention: Policy and Instruction
101 North 14th Street, 12th Floor
Richmond, VA 23219
Fax: **(804) 371-0231**

DHRM will approve all valid requests and forward them to Anthem. Anthem's Member Services team will contact you to obtain specific medication information. Once you provide

the medication information, a prior authorization will be entered for each medication requested and you will have 14 days to complete your purchase.

Please note:

- The maximum supply you may purchase at one time is 12 months;
- You will not be allowed to purchase more refills than prescribed. For example, if your one-year prescription expires six months from the date of your request, you cannot purchase more than a six-month supply of medication;
- You will be charged the appropriate Copayment for refills;
- The Food and Drug Administration limits refills on certain medications;
- Allow at least two weeks for complete processing of your request; and
- The Commonwealth reserves the right to bill a member for any months of medication remaining if employment terminates.

Pharmacy Management Services

1) **Dose Optimization**
   Your prescription drug program includes dose optimization. Dose optimization usually means increasing the strength of a medication so that you only have to take it once a day, instead of taking a lower dose two times each day. For example, a 10mg dose taken twice per day would be changed to a 20mg dose taken only once per day.

   The pharmacy will receive an electronic message if your drug requires dose optimization. Then, your pharmacist will:

   - Call your doctor to see if the dosage can be changed so you only have to take the drug once each day.
   - Talk to you and your doctor about other ways to meet the requirement, if needed.
   - Fill your prescription at the new dose.

   There may be Medical reasons why your doctor believes the original dosage is better for you. Your doctor may request a prior authorization review by calling **866-310-3666** to determine if your prescription plan can cover your medication dosage.

2) **Step Therapy**
   Your program includes step therapy for treating some conditions, which means that certain drugs must be tried first before using an alternative drug. Different drugs are tried in a step-by-step manner to determine which drug is the best option for you. When your doctor prescribes a drug that requires step therapy, a message is sent to your pharmacy that lets the pharmacist know that you must first try a different, but similar drug that is covered under your plan. The pharmacist will call your doctor to get a prescription for the new drug.

3) **Quantity Limits**
   Your prescription drug program has set amount and quantity limitations for some drugs. If you refill a prescription too soon or your doctor prescribes an amount that is higher than usual, your pharmacist will tell you, and the drug will not be covered at that time. You must obtain prior authorization to obtain quantities in excess of these limitations. Please visit **www.anthem.com/tlc** for a list of drugs that have quantity limitations.

4) **GenericSelect Program**
   If you are taking a brand name drug that has an equally effective generic alternative, you may receive a mailing about an opportunity to switch to the lower cost generic drug. If you make the switch, you will pay zero copayment for the first GenericSelect prescription.

5) **Prior Authorization**
   Certain medications require prior authorization. In these cases, Clinical criteria based on current Medical information and appropriate use must be met. Information must be provided before coverage is approved. Your Provider, or your local pharmacist may call **866-310-3666** toll-free to initiate a prior authorization. When you use Anthem's Home Delivery Pharmacy Service, they will call your Provider to start the prior authorization process. The review utilizes plan rules based on FDA-approved prescribing and safety information, clinical guidelines, and uses that are considered reasonable, safe, and effective. You will be notified in writing when a prescription is denied for coverage. Your Provider will be notified of both approval and denial decisions. For a list of drugs that require prior authorization visit **www.anthem.com/tlc** or call Anthem Member Services.

Members with questions pertaining to pharmacy management services should contact Anthem Member Services at **800-552-2682** for more information.

Special Limits

1) Up to a 34-day supply will be eligible for Reimbursement from a retail pharmacy.

2) 35 to 102-day supplies are eligible for Reimbursement from a retail pharmacy; however, multiple retail copays will apply.

3) Up to a 90 day supply may be obtained from Anthem's Home Delivery Pharmacy Services.

4) Only in documented cases of extended foreign travel will a supply of more than 90 days be prior authorized.

5) Replacement drugs for supplies lost, stolen, damaged, destroyed, etc. are not eligible for Reimbursement.

6) Benefits for any refill of a prescription drug will not be provided until the amount of time has elapsed from the previous dispensing of the prescription drug which would result in at least 75% of the drug being used if taken consistently with the prescribing Provider's directions.

7) Certain drugs may not be available through Anthem's Home Delivery Pharmacy Service due to distribution restrictions imposed by the drug manufacturer or the FDA. However, these drugs are available through the network retail pharmacies at their appropriate retail Copayment level.

8) Pharmacy claim Reimbursement requests must be received within 12 months after the end of the calendar year in which the services were received.

9) A prescription is needed for the purchase of diabetic supplies.

10) Wellness immunizations may be received at a participating Outpatient pharmacy. You will receive the same benefit as when you receive an immunization from your Provider's office. See the **Wellness and Preventive Care Services** section for more information on covered wellness and preventive immunizations.

11) Your Health Plan may initiate programs to encourage covered members to utilize more cost-effective or clinically-effective drugs, including, but not limited to, generic drugs, home delivery drugs, or preferred products. Such programs may involve reducing or waiving Copayments or Coinsurance for certain drugs or preferred products for a limited period of time.

12) Compound drugs are only covered when the primary ingredient, by cost, is FDA approved and not otherwise excluded by Your Health Plan.

Health Plan Reimbursement

1) Your Health Plan pays the remaining Allowable Charge after you pay the Copayment or Coinsurance. The Plan Administrator will determine whether a particular generic Outpatient Prescription Drug is equivalent to a brand name Outpatient Prescription Drug. If you or your Provider determine to fill the prescription with a brand name drug when a generic equivalent is available, you will be responsible not only for the brand Copayment, but also the difference between the Allowable Charge for the brand name drug and the Allowable Charge of its generic equivalent. The difference between the Allowable Charge for the brand named drug and Allowable Charge of its generic equivalent does not count towards the medical Out-of-Pocket Expense Limit. There is a maximum member cost each time a member purchases a brand name drug when a generic is available in the immunosuppressant, anticonvulsant, and psychotherapeutic drug categories.

2) If the dispensing pharmacy is a network pharmacy, the Plan Administrator will direct benefit payment to that pharmacy. If the dispensing pharmacy is a non-network pharmacy, the Plan Administrator will direct payment to the member.

   - A network pharmacy is a pharmacy listed as a network pharmacy by the Plan Administrator at the time the Outpatient Prescription Drug is dispensed.
   - A non-network pharmacy is any other pharmacy. You may be required by a non-network pharmacy to pay not only the Copayment, but also the difference between the pharmacy's charge for the Outpatient Prescription Drug and the Allowable Charge for the Outpatient Prescription Drug.

3) The benefits provided for services under this section are in lieu of any other benefits for the same services listed in any other section of this booklet. Any Copayment or Coinsurance listed for Outpatient Prescription Drug services will not be eligible for Reimbursement as a covered service under any other section.

4) The Plan Administrator may receive, directly or indirectly, financial credits from drug manufacturers whose products are included on formulary lists. Credits are received based on the utilization of the manufacturer's products by persons enrolled under contracts insured by or administered by the Plan Administrator. Credits received by virtue of the benefits provided under this section are retained by the Plan Administrator as a part of its compensation from TLC for administrative services. Payments to pharmacies are not adjusted as a result of these credits.

Member Pays

Prescription medications can be received in a Facility Setting or from a professional Provider. Some medications are covered as a Medical service. See the **Hospital Services** and **Medical, Surgical, and Behavioral Health Services** sections of this booklet.
When using your Outpatient Prescription Drug benefit, covered brand name and generic drugs are categorized into specific tiers and each tier is assigned a Copayment level.

Tier 1 – Lowest Copayment, typically generic drugs
Tier 2 – Moderate Copayment, typically lower-cost brand name drugs
Tier 3 – Higher Copayment, typically higher-cost brand name drugs

Refer to the Benefits Summary for the plan in which you are enrolled.

There is a maximum member cost for a brand name drug when a generic is available in the immunosuppressant, anticonvulsant, and psychotherapeutic drug categories. Members pay no more than $100 for each 34-day supply at retail and $200 for up to a 90-day supply at mail service. This includes the standard brand name drug Copayment.

General Information

Contact Anthem Member Services by calling toll-free **800-552-2682**.

Member Services representatives can:

- help you find a participating retail pharmacy;
- send your order forms or claim forms; and
- answer questions about your prescriptions or plan coverage.

TTY is available for hearing-impaired members. Call **800-355-8279**.

To order prescription labels printed in Braille
Braille labels are available for home delivery prescriptions. Call **800-355-8279**.

Online Services
If you have Internet access, you can take advantage of Anthem's web site and register at **www.anthem.com/tlc** to:

- compare the cost of brand name and generic drugs at retail and via mail order;
- access plan highlights;
- obtain order forms, claim forms, and envelopes;
- submit mail order refills; and check the status of Anthem's home delivery orders.

DENTAL SERVICES

DIAGNOSTIC AND PREVENTIVE DENTAL SERVICES

Administered by Delta Dental of Virginia

Services Which Are Eligible for Reimbursement

Your Health Plan provides coverage for you to see your dentist twice a year for a checkup. This allows your dentist to identify any possible problems and to try and prevent cavities and serious Dental problems. The following services are generally covered, but in some specific situations certain Exclusions and limitations apply. See **Special Limits** in this section and the **Exclusions** section of this booklet. Covered services include:

- two routine oral evaluations per Plan Year;
- two Dental prophylaxes (cleanings) per Plan Year, including scaling and polishing of teeth;
- Dental x-rays (except x-rays needed to fit braces);
- two sets of bitewing x-rays (two or more films) per Plan Year (vertical bitewings are considered a full mouth series);
- one complete full mouth x-ray series, or a panorex every 36 months (the 36-month count starts the month in which you receive the x-ray series or panorex);
- space maintainers used to keep teeth from moving into space left when deciduous teeth are pulled;
- two pulp vitality tests per tooth (to see if a tooth is still alive) every 12 months (the 12-month count starts the month in which you receive the pulp vitality test);
- care for a toothache (palliative Emergency care);
- two topical fluoride applications per Plan Year only to Covered Persons under age 19;
- Dental pit/fissure sealants to the unrestored occlusal surface of the first and second permanent molars (limited to one application per tooth). Dental pit/fissure sealants are available only to Covered Persons under age 19;
- occlusal adjustments, bite planes or splints for temporomandibular joint disorders; and
- occlusal night guards for demonstrated tooth wear due to bruxism; or occlusal orthotic device for treatment of temporomandibular joint dysfunction (TMJ). Services are limited to once in 36 months.

Conditions for Reimbursement

Members have access to the Delta Dental PPO or Premier networks. Should you decide to receive Dental care from a dentist who is not a member of the Delta Dental Premier or PPO networks, you will still receive benefits from your Dental plan, but your share of the cost will likely be higher than if you received care from a network dentist.

- You may have to file any claims yourself.
- Payment will be made directly to you unless your dentist agrees to accept payment from Delta Dental.
- You must pay the applicable Coinsurance and the difference between the non-network dentists' charges and Delta Dental's payment for covered benefits.

Special Limits

1) If you transfer from the care of one dentist to another during a course of treatment, the Plan Administrator will only pay the amount it would pay to one dentist for the same treatment.

2) If more than one dentist renders services for one procedure, the Plan Administrator will only pay the amount it would pay to one dentist for the same treatment.

3) If Dental services for a single procedure or series of procedures cost more than $250, it is recommended that your dentist submit a predetermination plan to Delta Dental before services are provided.

4) By submitting a predetermination plan, you and your dentist will be informed of the total costs associated with the procedure(s), the exact amounts that will be covered by Your Health Plan, and the portion of the charges for which you will be responsible. A predetermination plan is not required by Your Health Plan but recommended when extensive Dental work is expected. A claim will not be denied for failure to obtain a predetermination plan.

Health Plan Reimbursement

Your Health Plan pays the remaining Allowable Charge.

Member Pays

Refer to the Benefits Summary Insert for the plan in which you are enrolled.

COMPREHENSIVE DENTAL SERVICES

Administered by Delta Dental of Virginia

These services are covered only if you have selected the Comprehensive Dental option

Services Which Are Eligible for Reimbursement

1) Diagnostic and Preventive Care

Your Health Plan provides coverage for you to see your dentist twice a year for a checkup. This allows your dentist to identify any possible problems and to try and prevent cavities and serious Dental problems. The following services are generally covered, but in some specific situations certain Exclusions and limitations apply. See Special Limits in this section and the **Exclusions** section of this booklet. Covered services include:

- two routine oral evaluations per Plan Year;
- two Dental prophylaxes (cleanings) per Plan Year, including scaling and polishing of teeth;
- Dental x-rays (except x-rays needed to fit braces);
- two sets of bitewing x-rays (two or more films) per Plan Year (vertical bitewings are considered a full mouth series);
- one complete full mouth x-ray series, or a panorex every 36 months (the 36-month count starts the month in which you receive the x-ray series or panorex);
- space maintainers used to keep teeth from moving into space left when deciduous teeth are pulled;
- two pulp vitality tests per tooth (to see if a tooth is still alive) every 12 months (the 12-month count starts the month in which you receive the pulp vitality test);
- care for a toothache (palliative Emergency care);
- two topical fluoride applications per Plan Year only to Covered Persons under age 19;
- Dental pit/fissure sealants to the unrestored occlusal surface of the first and second permanent molars (limited to one application per tooth). Dental pit/fissure sealants are available only to Covered Persons under age 19;
- occlusal adjustments, bite planes or splints for temporomandibular joint disorders; and
- occlusal night guards for demonstrated tooth wear due to bruxism; or occlusal orthotic device for treatment of temporomandibular joint dysfunction (TMJ). Services are limited to once in 36 months.

2) Primary Dental care

- fillings (amalgam or composite resin materials);
- pin retention;
- simple extractions of natural teeth and surgical extractions of fully erupted teeth;
- root canal therapy (endodontics);
- care for abscesses in the mouth (excision and drainage);
- repair of broken removable dentures;
- surgical preparation of ridges for dentures;
- re-cementing existing crowns, inlays and bridges (once every 12 months);
- removing infected parts of the gum (gingivectomy and gingivoplasty);
- scaling and root planing of the teeth (once every 2 years per quadrant);
- stainless steel crowns for primary teeth only;
- sedative fillings;

- therapeutic pulpotomy;
- periodontal evaluation (not in addition to periodic evaluations);
- an operation to remove diseased portions of bone around the teeth (osseous surgery);
- soft tissue grafts to replace lost or unhealthy gum tissue;
- bone graft (only around natural teeth);
- guided tissue regeneration;
- general anesthesia in connection with a covered surgical Dental service is covered when three or more simple extractions are performed (not covered for deciduous teeth);
- crown lengthening when bone is removed and at least six weeks are allowed for healing;
- hemisection and root amputations;
- apicoectomies;
- intravenous conscious sedation when in conjunction with a surgical procedure;
- full mouth debridement (once per lifetime)
- core build ups (once per tooth every 5 years)
- periodontal maintenance limited to two per Plan Year;
- restorative (silver and tooth-colored fillings, primary teeth only stainless steel crowns, and other restorative services) retreatment limited to once per surface in a 2 year period; and
- trips by the dentist to your home if you need any of the services you see listed here.

3) Major Dental care

- inlays (limited to the benefit for a resin restoration unless part of partial or bridge abutment);
- onlays (limited to the benefit for a metallic restoration);
- crowns and crown repair (once per tooth every 5 years);
- labial veneers involving the incisal edge of anterior teeth, porcelain laminate (laboratory processed);
- Dental implants (once per tooth every 5 years);
- dentures (full and partial), and denture adjustments and relining; and
- fixed bridges and repair.

4) Orthodontic benefits

- orthodontic appliances (installing only, no replacement or repair);
- services needed to diagnose the problem, including x-rays, study model and diagnostic casts;
- tooth guidance and harmful habit appliances;
- interceptive treatment;
- surgical access of unerupted teeth when performed for orthodontic purposes; and
- orthodontic evaluations when no treatment is initiated.

Conditions for Reimbursement

1) Members have access to the Delta Dental PPO or Premier networks. Should you decide to receive Dental care from a dentist who is not a member of the Delta Dental Premier or PPO networks, you will still receive benefits from your Dental plan, but your share of the cost will likely be higher than if you received care from a network dentist.

- You may have to file any claims yourself.
- Payment will be made directly to you unless your dentist agrees to accept payment from Delta Dental.

- You must pay the applicable Coinsurance and the difference between the non-network dentists' charges and Delta Dental's payment for covered benefits.

2) Delta Dental must approve permanent crowns for Covered Persons under age 16 in advance.

3) Replacement of prosthetic appliances, dentures, crowns, crown buildups, post and core to support crowns, onlays and bridges are limited to once every five-year period. There is one exception: replacement of a bridge will be provided prior to the end of the five-year period if one or more abutment teeth are extracted.

4) Orthodontic Services

- Your Health Plan makes periodic payments for covered orthodontic services up to the benefit maximum over the entire course of treatment. Your Health Plan will pay up to $500 at the time of initial banding. Your Health Plan pays the balance of its obligation over the remainder of the treatment period. In the event you make payment in full at the time of initial banding, Your Health Plan will pay as if you are making periodic payments over the treatment period.
- If orthodontic treatment begins before your Effective Date, Your Health Plan reduces its total allowance by the amount paid by a prior carrier, or the prior carrier is obligated to pay.
- If your coverage ends during orthodontic treatment, Your Health Plan covers:

    1) the banding portion of the service only if the bands are installed before the date your coverage ends; or
    2) follow-up Visits if enrolled on the first day of the month when the Visit takes place.

Special Limits

1) A Plan Year Deductible applies to routine primary and major Dental care services. Refer to the Benefits Summary Insert for the plan in which you are enrolled.

2) Benefits for routine primary and major Dental services have Plan Year limits. Benefits for Orthodontic services have a lifetime maximum. Refer to the Benefits Summary Insert for the plan in which you are enrolled.

3) Annual benefit maximums will not apply toward diagnostic & preventive services, primary services or major services for any covered member under the age of 19.

4) Orthodontic maximum may be waived for dependents under age 19 if treatment is deemed Medically Necessary.

5) If you transfer from the care of one dentist to another during a course of treatment, the Plan Administrator will only pay the amount it would pay to one dentist for the same treatment.

6) If more than one dentist renders services for one procedure, the Plan Administrator will only pay the amount it would pay to one dentist for the same treatment.

7) If Dental services for a single procedure or series of procedures cost more than $250, it is recommended that your dentist submit a predetermination plan to Delta Dental before services are provided.

8) By submitting a predetermination plan, you and your dentist will be informed of the total costs associated with the procedure(s), the exact amounts that will be covered by Your Health Plan, and the portion of the charges for which you will be responsible. A predetermination plan is not required by Your Health Plan but recommended when extensive Dental work is expected. A claim will not be denied for failure to obtain a predetermination plan.

Health Plan Reimbursement

Your Health Plan pays the remaining Allowable Charge after your Deductible and Coinsurance for Dental services.

Member Pays

Refer to the Benefits Summary Insert for the plan in which you are enrolled.

DENTAL SERVICES – NON-ROUTINE MEDICAL

Administered by Anthem Blue Cross and Blue Shield

Services Which Are Eligible for Reimbursement

1) Non-routine Medical benefits for oral surgery:

   - surgical removal of impacted teeth;
   - maxillary or mandibular frenectomy when not related to a Dental procedure;
   - alveolectomy when related to tooth extraction;
   - orthognathic surgery that is required because of a Medical condition or injury which prevents normal function of the joint or bone and is deemed Medically Necessary to attain functional capacity of the affected part;
   - surgical services on the hard or soft tissue in the mouth when the main purpose is not to treat or help the teeth and their supporting structures;
   - the treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia;
   - Dental services and Dental appliances furnished when required to treat medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia; and
   - Dental services to prepare the mouth for radiation therapy to treat head and neck cancer.

2) Non-routine Medical benefits for accidental injury:

   - Medically Necessary Dental services when required to diagnose and treat an accidental injury to the teeth if the accident occurs while you are covered under Your Health Plan; and
   - the repair of Dental appliances damaged as a result of accidental injury to the jaw, mouth or face.

Conditions for Reimbursement

1) A Health Services Review is recommended prior to an oral surgery procedure.

2) Dental services resulting from an accidental injury are covered, provided that, for an injury occurring on or after your Effective Date of coverage you:

   - seek treatment within 60 days after the injury; and
   - submit a plan of treatment from your dentist or oral surgeon for prior approval by Anthem.

   Services and appliances are covered for adults if rendered within a two-year period after the accidental injury. The two-year restriction may be waived for children under age 18. Actual treatment may be delayed if tooth/bone maturity is in question and standard industry protocols are followed. However, a treatment plan must be filed within six months of the accident and treatment must be completed within two years of active treatment commencement and prior to age 20. For the waiver to be granted, continuous coverage under Your Health Plan is required.

3) Your Health Plan provides coverage for the following services through the Medical benefits:

- covered general anesthesia and hospitalization services for children under the age of 5, Covered Persons who are severely disabled, and Covered Persons who have a Medical condition that requires admission to a hospital or Outpatient surgery Facility; and
- services for general anesthesia and hospitalization services only when it is determined by a licensed dentist, in consultation with the Covered Person's treating physician, that such services are required to effectively and safely provide Dental care.

Special Limits

1) Non-routine Dental services covered under the Medical benefit are subject to the Medical Plan Year Deductible and Out-of-Pocket Expense Limit.

2) Injury as a result of chewing or biting is not considered an accidental injury and would not be covered by the health plan under Medical services.

Health Plan Reimbursement

Your Health Plan pays the remaining Allowable Charge after your Deductible, Copayment or Coinsurance.

Member Pays

Refer to the Benefits Summary Insert for the plan in which you are enrolled.

ROUTINE VISION SERVICES

Administered by Anthem Blue Cross and Blue Shield (Blue View Vision network)

The Blue View Vision network is for routine eye care only and is a separate network from the Anthem Medical network. Non-routine vision care is covered under your Anthem Medical benefits.

Services Which Are Eligible for Reimbursement

1) Routine vision examination.

2) Frames and eyeglass lenses or contact lenses to correct vision.

Conditions for Reimbursement

Vision services must be:

- billed for by a licensed ophthalmologist, optometrist, or optician;
- services which the Provider is licensed to render;
- services received in-network will be covered according to in-network benefits; and
- services received Out-of-Network will be reimbursed according to the Out-of-Network allowance.

Special Limits

1) This benefit is available once per Plan Year. This includes the routine vision examination and eyeglasses (frames and lenses) or contact lenses.

2) Covered materials that are lost or broken will be replaced only at normal service intervals indicated in the plan design. However, these materials and any items not covered below may be purchased at preferred pricing from a Blue View Vision Provider.

3) Benefits cannot be combined with any offer, coupon, or in-store advertisement.

4) Discounts are not available for certain brand name frames in which the manufacturer imposes a no discount policy.

Health Plan Reimbursement

Your Health Plan pays the remaining Allowable Charge for the routine vision examination and other covered materials after your benefit payment.

Member Pays	**In-Network**
Routine vision examination	Specialist Copayment. *Refer to the Benefits Summary Insert for the plan in which you are enrolled.*
Eyeglass frames	20% discount after plan pays first $100

Standard eyeglass lenses *(one of the following)*

• Standard plastic single vision lenses (1 pair)	$20 Copayment
• Standard plastic bifocal lenses (1 pair)	$20 Copayment
• Standard plastic trifocal lenses (1 pair)	$20 Copayment

Note: Polycarbonate lenses included for children under 19 years old.

Upgrade eyeglass lenses

In addition to the standard eyeglass lens Copayment, you may choose to add one or more of the upgrades below for the additional Copayment(s).

• UV coating	$15
• Tinted lenses *(solid and gradient)*	$15
• Standard scratch-resistance	$15
• Standard polycarbonate	$40
• Standard progressive *(add-on to bifocal)*	$65
• Standard anti-reflective coating	$45
• Other add-ons and services	20% off retail price

Contact lenses

You may choose to receive contact lenses instead of eyeglasses (frames and lenses).

• Elective conventional lenses	15% discount after plan pays $100
• Elective disposable lenses	Balance after plan pays $100
• Non-elective contact lenses	Balance after plan pays $250

Elective contact lenses are in lieu of eyeglasses (frames and lenses). Non-elective lenses are covered when glasses are not an option for vision correction.

Contact lens fitting and follow-up

A contact lens fitting and up to two follow-up Visits are available to you once a comprehensive eye exam has been completed. The initial contact lens fitting must be performed during your comprehensive eye exam for the service to be covered.

Standard contact fitting — You pay up to $55

A standard contact lens fitting includes spherical clear contact lenses for conventional wear and planned replacement. Examples include, but are not limited to, disposable and frequent replacement lenses.

Premium contact lens fitting 10% off of retail price

A premium contact lens fitting includes all lens designs, materials and specialty fittings other than standard contact lenses. Examples include, but are not limited to, toric and multifocal lenses.

Additional savings on eyewear and accessories

After you use your initial frame or contact lens benefit allowance, you can take advantage of discounts on additional prescription eyeglasses, conventional contact lenses, and eyewear accessories at Blue View Vision network Providers at any time. The once per Plan Year restriction does not apply. Blue View Vision's Additional Savings Program is subject to change without notice.

- Additional complete pair of eyeglasses (as many as you like) 40% off retail
- Conventional contact lenses (materials only) 15% off retail
- Additional eyewear & accessories 20% off retail
  (Includes eyeglass frames and eyeglass lenses purchased separately, some non-prescription sunglasses, eyeglass cases, lens cleaning supplies, contact lens solutions, etc.)

How to find a Blue View Vision Provider

Before you seek routine vision services, be sure to locate a Blue View Vision Provider. Go to Find a Doctor at **www.anthem.com/tlc** or call Anthem Member Services at **800-552-2682** for help.

Always tell your routine vision Provider if you have Anthem's Blue View Vision. Network Providers can check your eligibility and automatically file your claims. When you receive care from a Blue View Vision participating Provider, you receive the greatest benefits and money-savings discounts.

Out-of-Network routine vision services

You can choose to receive care outside of the Blue View Vision network. The following allowances apply.

- Routine eye exam $50 allowance
- Eyeglass frames $80 allowance
- Standard plastic single vision lenses (1 pair) $50 allowance
- Standard plastic bifocal lenses (1 pair) $75 allowance
- Standard plastic trifocal lenses (1 pair) $100 allowance
- Standard progressive *(add-on to bifocal)* $75 allowance
- Elective conventional and disposable lenses $80 allowance
- Non-elective contact lenses $210 allowance

You must pay in full at the time of service and then submit a claim and itemized receipt for Reimbursement. Go to **www.anthem.com/tlc** for an Out-of-Network claim form. Out-of-Network claims under Blue View Vision must be submitted within one year from the original date of service.

INDIVIDUAL CASE MANAGEMENT PROGRAM

Individual case management is included under your Medical and Behavioral Health benefits. In addition to the covered services listed in this booklet, Your Health Plan may elect to offer benefits for an approved alternate treatment plan for a patient who would otherwise require more expensive covered services. This includes, but is not limited to, long term Inpatient care. Your Health Plan will provide alternate benefits at its sole discretion.

Your Health Plan will do so only when and for so long as it decides that the services are Medically Necessary and cost effective. The total benefits paid for such services may not exceed the total that would otherwise be paid without alternate benefits. If Your Health Plan elects to provide alternate benefits for a Covered Person in one instance, it will not be required to provide the same or similar benefits for any Covered Person in any other instance. Also, this will not be construed as a waiver of Your Health Plan's right to enforce the terms of Your Health Plan in the future in strict accordance with its express terms.

Also, from time to time Your Health Plan may offer a Covered Person and/or their Provider or Facility information and resources related to disease management and wellness initiatives. These services may be in conjunction with the Covered Person's Medical condition or with therapies that the Covered Person receives, and may or may not result in the provision of alternative benefits as described in the preceding paragraph.

BLUECARD PROGRAM

For Medical and Behavioral Health services

BlueCard® PPO for Care within the United States

If you need Medical care outside the Anthem PPO network and within the United States, you will have access to care from a BlueCard PPO Provider. Through the BlueCard PPO program, your Anthem Blue Cross and Blue Shield ID card is accepted by physicians and hospitals throughout the country who participate with another Blue Cross Blue Shield company. These Providers accept your Copayment or Coinsurance at the time of service instead of requiring full payment. They file claims directly to their local Blue Cross Blue Shield company (host Blue plan) for you, and have agreed to accept the Allowable Charge established by the local company as payment in full.

To locate a BlueCard PPO physician or hospital call BlueCard Access at **800-810-BLUE (2583)** or you may obtain this information on the Web at **www.bcbs.com**.

Simply present your Anthem ID card when you receive care. The PPO suitcase logo on your ID card tells the physician or hospital that your Medical plan includes the BlueCard PPO program.

How Charges Are Calculated for BlueCard PPO Services

If the amount you pay for a covered service is based on the charge for that service, the charge used to calculate your part will be the lower of:

- the billed covered charges for the covered services; or
- the negotiated price passed on to Anthem by the local Blue Cross and/or Blue Shield Plan.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the host Blue plan pays to your health care Provider. Sometimes, it is an estimated price that takes into account special arrangements with your health care Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of health care Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price used for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the host Blue plan to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, the plan would then calculate your liability for any covered health care services according to applicable law.

Blue Cross Blue Shield Global Core for Care outside the United States

If you live or travel outside the United States, the Blue Cross Blue Shield Global Core program assists you to obtain Inpatient and Outpatient hospital care and physician services.

Follow these steps before you travel:

1) Obtain a list of BCBS Global Core hospitals located where you will be traveling or staying. You may obtain this information on the Web at **www.bcbs.com** and select the "Healthcare Coverage" tab, or call BCBS Global Core at **800-810-BLUE (2583)** for assistance locating a Provider.

2) Be sure to carry your Anthem Medical ID card with you and present it when you need Inpatient care.

3) **In an Emergency, go to the nearest hospital.**

4) If you need to find a doctor or hospital, or need help getting health care, call the **BCBS Global Core Service Center toll free at 800-810-BLUE (2583) or call collect at 804-673-1177**, 24 hours a day, seven days a week. An assistance coordinator, along with a health care professional, will help you with a doctor office Visit or if you need to stay in a hospital.

5) Call the **BCBS Global Core Service Center toll free at 800-810-BLUE (2583) or call collect at 804-673-1177 when you need 24-hour care (Inpatient) in a hospital.** In most cases, you should not need to pay up front for Inpatient care at participating BCBS Global Core hospitals. You will have to pay for the Out-of-Pocket fees (non-covered services, Deductible, Copayment and Coinsurance) you normally pay. The hospital should send your claim for you. After you contact the BCBS Global Core Service Center, you should also call an Anthem Member Services representative for Precertification or prior approval. You can find the phone number on your ID card. Note: This number is not the same as the phone number above.

6) You will need to pay up front for care you get from a non-participating doctor and/or hospital. Then, fill out a BCBS Global Core claim form and send it with the bill(s) to the BCBS Global Core Service Center at the address on the form. You can get the claim form from the BCBS Global Core Service Center or online at **www.bcbsglobalcore.com**.

PROGRAMS INCLUDED IN YOUR HEALTH PLAN

Future Moms

Administered by Anthem

You (or your covered dependent) are eligible to participate in the Future Moms program. This program is designed to help women have healthy pregnancies and healthy babies. A nurse works with the mother and her doctor throughout the pregnancy to help avoid complications and to help ensure that the baby is born at a healthy weight.

As soon as pregnancy is confirmed, sign up for the program by calling **800-828-5891**. You will receive:

- toll-free access to a registered nurse, any time day or night, in case you have questions or concerns along the way;
- a prenatal book to help you follow your pregnancy week by week, materials to help you handle the unexpected; and
- postpartum support and guidance in areas like breastfeeding and depression.

The Future Moms program includes three assessments – initial, 28 week and postpartum. Based on the information from the initial assessment, the nurse determines whether the mother-to-be is at a low or high risk for a healthy pregnancy. High risk members will receive outbound calls from a nurse to monitor the pregnancy more closely. Any member can call in to the program at any time with questions.

Future Moms Incentive

For Key Advantage Expanded and Key Advantage 250 members - Your Health Plan may waive the maternity hospital Stay Copayment when you enroll in Future Moms if you meet the following requirements:

- Enroll in Future Moms during the first trimester of pregnancy (14 weeks).
- Actively participate and complete all Future Moms program requirements.
- Have at least one Dental cleaning during your pregnancy.

You will receive an incentive welcome letter if you enroll in the Future Moms program in the first trimester. When you complete the Future Moms program and have your Dental cleaning, you will receive a letter to present to the hospital when you go in for your delivery advising the hospital that your Inpatient Copayment is waived.

Call **800-828-5891** to enroll and receive additional information.

You must add your newborn to Your Health Plan **within** the timeframe allowed by the group's flexible benefits document and no more than 60 days from the date of birth**, or your newborn will not be covered.**

ConditionCare

Administered by Anthem

If you or a family member are living with asthma, diabetes, coronary artery disease (CAD), heart failure, chronic obstructive pulmonary disease (COPD), hypertension, hyperlipidemia, or obesity, you know the impact that it has on your life. ConditionCare is a confidential disease

management program that provides the tools and support needed to minimize your condition's effects, improve your health and help you feel better.

ConditionCare is a voluntary program. To register for this program, call **800-445-7922**. A ConditionCare nurse will be available to answer your questions, help you coordinate your benefits, and provide support to help you follow your doctor's plan of treatment. When you call, please be sure to have your health insurance ID card and physician's name and address available.

In addition to members calling to enroll, the program receives the names of members who may have certain chronic health conditions from Medical and pharmacy claims, and case managers. You may be contacted by a ConditionCare enrollment specialist to find out if you or any of your eligible family members would like to participate in this program. With your permission, your health care information will be verified and will be shared with the ConditionCare staff and your physician. If your condition is under control or you are not interested in participating in the program, feel free to contact ConditionCare at **800-445-7922** to notify an enrollment specialist that you are not interested and do not wish to be contacted further.

LiveHealth Online

Administered by Anthem

LiveHealth Online lets you have a face-to-face doctor Visit from your mobile device or computer with a webcam, 24 hours a day. The cost is the same as a Primary Care Physician Visit. Some of the most common conditions that can be treated through LiveHealth Online are cold and flu symptoms including cough, fever and headache, sinus and ear infections, and allergies. LiveHealth Online has a broad network of board-certified doctors who average 15 years of experience practicing medicine and are specially trained to provide online Visits. You can choose the doctor that's right for you and begin your consultation in minutes. In Virginia and several other states who allow it by law, the doctor can also call in a prescription at the pharmacy of your choice.

To get started, sign up at **www.livehealthonline.com**, or download the app to your smartphone or tablet.

In addition to a face-face doctor Visit from your mobile device or computer, you may use LiveHealth Online to talk with a counselor at no cost as part of your EAP benefit. Call 1-855-223-9277 to get your coupon code and instructions on how to make your first appointment.

You may also make an appointment with a licensed therapist, psychologist or psychiatrist. Unlike therapists who provide counseling support, psychiatrist can also provide medication management. Schedule online at **www.livehealthonline.com** or call 1-844-784-8409 to make an appointment. The cost is the same as an Outpatient Behavioral Health office Visit.

24/7 NurseLine and AudioHealth Library

Administered by Anthem

Illness or injury can happen, no matter what time of day. As an Anthem health plan member, you have access to a team of nurses to assist with your questions or concerns 24 hours a day, seven days a week. These registered nurses can discuss symptoms you are experiencing, how to get the right care in the right Setting and more. You can call as often as you like. Call **800-337-4770**.

For those who aren't comfortable discussing their health concerns with someone else or those just looking for more information on a health topic, the AudioHealth Library has more than 300 recorded health topics. Call **800-337-4770** to access this library. For the list of topics, go to **www.anthem.com/tlc** and select 24/7 NurseLine under Special Programs.

Employee Assistance Program (EAP)

Administered by Anthem

In today's fast-paced world, juggling work, your personal life and all the associated demands and pressures can feel overwhelming. Fortunately, you have somewhere to turn. The Employee Assistance Program (**EAP**) administered by Anthem Behavioral Health provides up to four Visits per issue per Plan Year.

The EAP helps you resolve personal problems before they negatively affect your health, relationships with others, or job performance. You can contact the EAP 24 hours a day, 365 days a year, by simply calling **855-223-9277**. If you live or travel outside the United States, you also have access to your EAP benefits by calling **855-223-9277**.

The EAP provides confidential, professional counseling, education, and referral services to you, covered dependents and members of your household on a variety of issues including:

- marital and family problems
- child or adult care issues
- alcohol and/or drug abuse
- balancing work and family
- legal and financial
- stress management
- depression and anxiety
- work-related concerns
- career transition issues
- personal growth and development
- ID theft recovery

Information is also available at **www.AnthemEAP.com**, and includes a wealth of educational materials and resources related to Behavioral Health and wellness issues. The site offers information, interactive tools and resources on topics including balancing work and family, your health, taking care of dependents, relationships and life skills.

Included with your EAP is the MyStrength online tool, a free resource to help you and your family members deal with chronic pain, depression, substance abuse and anxiety.

To access your EAP site, log on to **www.AnthemEAP.com. The Company name is Commonwealth of Virginia.**

MyHealth Advantage

Administered by Anthem

MyHealth Advantage is a program where we review your health claims, prescription drugs and lab results, and let you know if we find ways that may help you make the best use of your health plan coverage. For example, we may see that you can save money by switching to a generic drug. We check to see what medications you're taking and alert your doctor if we spot a potential drug interaction. We also keep track of your routine tests and checkups. We provide recommendations and reminders by mailing you a MyHealth Note. This is a confidential health summary that includes prescription drug updates, money-saving tips such as going to an urgent care versus an emergency room, reminders for check-ups, tests and exams, and other personalized health suggestions.

ComplexCare Program

Administered by Anthem

This program helps members living with multiple health care issues. Our goal is to help you access quality care, learn to effectively manage your condition and lead the healthiest life possible. When you enroll in the program, you're assigned to a nurse care manager who specializes in helping high-risk people. The nurse care manager will work with you and your doctor to create an individualized care plan, coordinate care between different doctors and health care Providers, develop personalized goals, offer health and lifestyle coaching, answer your questions and more.

Healthy Smile, Healthy You™

Administered by Delta Dental of Virginia

Growing evidence confirms the connection between oral health and overall general health. Delta Dental of Virginia's Healthy Smile, Healthy You™ program provides additional benefits for three important health conditions connected to oral health: pregnancy, diabetes and high risk cardiac conditions.

- Pregnant members enrolled in the Future Moms program are eligible for one additional Dental cleaning and exam, or periodontal maintenance Visit (if the member has a history of periodontal surgery) during the term of their pregnancy, in addition to the normal plan frequency limits.
- Diabetic and/or High Risk Cardiac members enrolled in the ConditionCare program are eligible for one additional Dental cleaning and exam, or periodontal maintenance Visit (if the member has a history of periodontal surgery) during the Plan Year.

CommonHealth Wellness Program

Administered by Department of Human Resource Management (DHRM)

Helping individuals get and stay healthy is the main objective of CommonHealth, the Commonwealth's workforce wellness program. CommonHealth offers free programs delivered to participants wherever they are, and in a format best for them, whether at work, through video, or online. It includes Medical screenings, such as cholesterol and blood pressure checks; help to quit smoking and stay tobacco-free; health education on a variety of topics and other activities. For more information, visit **www.commonhealth.virginia.gov/tlc.**

EXCLUSIONS

The following services are not eligible for Reimbursement under any circumstances.

A

Your coverage does not include benefits for **acupuncture**.

B

Exclusions for **Behavioral Health** services, administered by Anthem Behavioral Health, are listed here and within the body of this booklet. Check both places for a complete listing. Your coverage does not include benefits for the following **mental health services and substance abuse services:**

- cognitive rehabilitation therapy;
- educational therapy or services, including:
  - remedial or special education services
  - psychological testing for educational purposes
  - vocational and recreational activities
  - any testing, therapy, service, supply or treatment for personal or professional growth
  - training for professional certification, development, or treatment relating to employment, regardless of whether investigational or pre or post-employment
  - other educational services
- court ordered psychiatric or substance abuse treatment except when the plan determines that such services are Medically Necessary for the treatment of a mental health diagnosis;
- treatment of social maladjustment without signs of a psychiatric disorder;
- coma stimulation therapy;
- pastoral counseling by an unlicensed network Provider;
- any testing, therapy, service, supply, or treatment for conditions that are identified by the Diagnostic and Statistical Manual of Mental Disorders (current edition) as not being attributable to a mental disorder but are additional conditions that may be a focus of clinical attention (i.e., V-codes);
- Experimental or Investigative therapies;
- any testing, therapy, service, supply or treatment of organic disorders, dementia, and primary neurological, neurodevelopmental, or neurocognitive disorders, except for associated treatable and acute behavioral manifestations;
- therapies which do not meet national standards for mental health professional practice or which have not been found to be effective or beneficial;
- Inpatient Stays for environmental changes;
- Inpatient services for substance abuse treatment that are custodial, or domiciliary in nature;
- examination in an Inpatient Setting that is not related to the Behavioral Health diagnosis;
- Inpatient treatment or Inpatient Stay for conditions requiring only Observation, diagnostic examinations, or diagnostic laboratory testing;
- Custodial Care, halfway house or domiciliary care & services;
- Skilled Nursing Facility (SNF) care for psychiatric conditions;

- Inpatient treatment which might safely and adequately be rendered in a less intensive level of institutional care; and
- Wilderness Programs and Equine Therapy.

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

Your coverage does not include storage of **blood** by any Provider or Facility other than a hospital.

C

Your coverage does not include benefits for:

- over-the-counter **convenience** and hygienic items. These include, but are not limited to, adhesive removers, cleansers, underpads, and ice bags;
- **cosmetic surgeries and procedures** performed mainly to improve or alter a person's appearance including body piercing and tattooing. A cosmetic surgery or procedure does not include a surgery or procedure to correct deformity caused by disease, trauma, or a previous therapeutic process, or to correct congenital abnormalities that cause functional impairment. The patient's mental state will not be considered in deciding if the surgery is cosmetic; or
- **Custodial Care** and services.

D

Exclusions for **Dental** services, administered by Delta Dental, are listed here and within the body of this booklet. Check both places for a complete listing.

- Dental supplies;
- brush biopsies of the oral cavity;
- services rendered after the date of termination of the Covered Person's coverage. There is one exception. Covered prosthetic services which are prepped or ordered before the termination date are covered if completed within 30 days following the termination date;
- gold foil restorations;
- athletic mouth guards;
- temporary dentures, crowns or duplicate dentures;
- oral or inhalation sedation;
- bleaching of discolored teeth;
- Dental pit/fissure sealants on other than first and second permanent molars;
- root canal therapy on other than permanent teeth;
- upgrading of working Dental appliances;
- precision attachments for Dental appliances;
- tissue conditioning;
- separate charges for infection control procedures and procedures to comply with Occupational Safety and Health Administration (OSHA) requirements;
- separate charges for routine irrigation or re-evaluation following periodontal therapy;
- analgesics (nitrous oxide);
- general anesthesia and IV sedation except in conjunction with oral surgery, surgical periodontia, or surgical endodontia and then only when the underlying Dental service is a covered benefit;
- diagnostic photographs;

- periodontal splinting and occlusal adjustments for periodontal purposes;
- occlusal analysis;
- controlled release of medicine to tooth crevicular tissues for periodontal purposes;
- tooth desensitizing treatments;
- care by more than one dentist when you transfer from one dentist to another during the course of treatment;
- care by more than one dentist for one Dental procedure, or by someone other than a dentist or qualified Dental hygienist working under the supervision of a dentist;
- preventive control programs, or oral hygiene instructions;
- complimentary services or Dental services for which the member would not be obligated to pay in the absence of the coverage under Your Health Plan or any similar coverage;
- Dental services for lost, misplaced or stolen prosthetic devices including orthodontic retainers, space maintainers, bridges and dentures (among other devices);
- services that Delta Dental determines are for the purpose of cosmetic surgery or dentistry for cosmetic purposes;
- services that Delta Dental determines are for the purpose of correcting congenital malformations or replacing congenitally missing teeth;
- Dental services for increasing vertical dimension, restoring occlusion, correcting developmental malformations, or for esthetic purposes;
- services billed under multiple Dental service procedure codes which Delta Dental, in its sole discretion, determines should have been billed under a single, more comprehensive Dental service procedure code. Delta Dental's payment is based on the allowance for the more comprehensive code, not on the allowances for the underlying component codes; and
- any services not listed as covered under **Dental services** in the **What is covered** section or services determined by Delta Dental, in its sole discretion, to be not necessary or customary for the diagnosis or treatment of the condition. Delta Dental will take into account generally accepted Dental practice standards in the area in which the Dental service is provided. In addition, a Covered Person must have a valid need for each covered benefit. A valid need is determined in accordance with generally accepted standards of dentistry.

E

Your coverage does not include:

- benefits for **educational** services except as otherwise specified in this booklet or when received as part of a covered wellness services Visit or screening; and
- any services covered by Individuals with Disabilities Education Act (IDEA) except as covered by Early Intervention Services.

Your Health Plan does not include coverage for **Experimental/Investigative** procedures, except for clinical trial costs for cancer. The criteria for deciding whether a service is Experimental/Investigative or a Clinical Trial Cost for cancer are described in the **Definitions** section and **General Rules Governing Benefits** section of this booklet.

F

Your coverage does not include benefits for certain **family planning** services. These include:

- services for artificial insemination or in vitro fertilization to include genetic testing for pre-implantation of an embryo or any other types of artificial or surgical means of conception, including any drugs administered in connection with these procedures;

- medications used to treat infertility even if they are used for an indication other than fertility; or
- services for abortions, except in the following circumstances and only if not otherwise contrary to law: when Medically Necessary to save the life of the mother; when the pregnancy occurs as a result of rape or incest which has been reported to a law enforcement or public health agency; or when the fetus is believed to have an incapacitating physical deformity or incapacitating mental deficiency which is certified by a Provider.

Your coverage does not include benefits 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, calluses and care of toenails (except as treatment for patients with diabetes or vascular disease);
- bunions (except capsular or bone surgery);
- fallen arches;
- weak feet;
- chronic foot strain; or
- symptomatic complaints of the feet.

H

Your coverage does not include benefits for **routine hearing care** for a hearing loss that is not due to a specific illness or injury, and routine hearing examinations, except hearing screenings as covered under **Wellness and Preventive Care Services.**

Your coverage does not include benefits for **hearing aids and hearing supplies**, except for children under the age of 3 who qualify for **Early Intervention Services**.

Your coverage does not include benefits for the following **Home Health Services**:

- homemaker services;
- maintenance therapy;
- food and home-delivered meals; or
- Custodial Care and services.

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

- guest meals, telephones, televisions, and any other convenience items received as part of your Inpatient Stay; or
- care by interns, residents, house physicians, or other Facility employees that are billed separately from the Facility.

I

Your coverage does not include benefits for **immunizations** required for travel and work unless such services are received as part of the covered preventive care services as defined in the **Wellness and Preventive Care** section of this booklet.

M

Your coverage does not include benefits for the following maternity services:

- doulas (labor assistants);
- childbirth classes;
- birthing centers; or
- midwives, unless certified nurse midwives.

Your coverage does not include benefits for **Medical Equipment (durable), appliances and devices, and Medical supplies** that have both a non-therapeutic and therapeutic use, such as:

- blood pressure cuffs;
- exercise equipment;
- air conditioners, dehumidifiers, humidifiers, and purifiers;
- hypoallergenic bed linens;
- whirlpool baths;
- handrails, ramps, elevators, and stair glides;
- telephones;
- adjustments made to a vehicle;
- foot orthotics;
- changes made to a home or place of business; or
- repair or replacement of equipment you lose or damage through neglect.

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

Your coverage does not include benefits for **Medical foods**.

Your coverage does not include benefits for services and supplies if they are deemed not **Medically Necessary** as determined by Your Health Plan at their sole discretion. Nothing in this Exclusion will prevent you from appealing Your Health Plan's decision that a service is not Medically Necessary.

However, if you receive Inpatient or Outpatient services that are denied as not Medically Necessary, certain Provider services that you receive during your Inpatient Stay or as part of your Outpatient services will not be denied under this Exclusion in spite of the Medical necessity denial of the overall services. See **Special Limits** under **Professional Services**.

N

Your coverage does not include benefits for nutritional counseling and related services, except when provided as part of counseling for adults at higher risk of chronic disease, for the treatment of an eating disorder, or when received as part of a well Visit service or screening.

O

Your coverage does not include benefits for care of **obesity** or services related to weight loss or dietary control, except as outlined in the **Wellness and Preventive Care** section. This includes weight reduction therapies/activities, even if there is a related Medical problem. Treatment for morbid obesity is covered as set forth in the **Professional Services** section.

Your coverage does not include benefits for **organ or tissue transplants** except as outlined under the **General Rules Governing Benefits** section.

Your **Outpatient Prescription Drug** benefit does not include coverage for:

- over-the-counter drugs (except certain preventive OTC products as outlined in the **Wellness and Preventive Care Services** section of this handbook);
- any per unit, per month quantity over the plan's 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, except in conjunction with covered treatment of morbid obesity;
- therapeutic devices or appliances;
- injectable Outpatient 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;
- medicine covered by workers' compensation, Occupational Disease Law, state or government agencies;
- medicine furnished by any other drug or Medical service;
- medications used to treat infertility even if they are used for an indication other than fertility; or medications used to treat short stature syndrome;
- replacement drugs or supplies lost, stolen, damaged, destroyed, etc.; or
- compound medications unless the primary ingredient (the highest cost ingredient) is FDA-approved, the medication requires a prescription to dispense, and is not essentially the same as an FDA-approved product from a drug manufacturer.

P

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

Your coverage does not include benefits for **private duty nurses** in the Inpatient Setting.

Your coverage does not include benefits for **Providers** not listed in the **Definition**s section of this handbook. For example, a naturopathic doctor is not considered a Provider.

R

Your coverage does not include **repatriation** (transportation to or from the United States).

Your coverage does not include the following Provider services for **Residential Treatment Center/Facilities:**

- nursing care;
- rest care;
- convalescent care;
- care of the aged;
- Custodial Care; or
- educational care.

See the Behavioral Health Services and Employee Assistance Program (EAP) Section for covered Services under the **Residential Treatment Program**.

S

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

- student health centers;
- ordered by a doctor whose services are not covered under Your Health Plan;
- care of any type given along with the services of an attending Provider whose services are not covered;
- not listed as covered under Your Health Plan;
- not prescribed, performed, or directed by a Provider licensed to do so;
- received before the Effective Date of coverage or after a Covered Person's coverage ends;
- telephone consultations or consultations by other electronic means, except as defined by Telemedicine, charges for not keeping appointments, or charges for completing claim forms;
- for travel, whether or not recommended by a physician;
- given by a member of the Covered Person's immediate family;
- provided under federal, state, or local laws and regulations. This includes Medicare and other services available through the Social Security Act of 1965, as amended, except as provided by the Age Discrimination Act. This Exclusion applies whether or not you waive your rights under these laws and regulations. It does not apply to laws that make the government program the secondary payor including TRICARE, after benefits under this policy have been paid.
- provided under a U. S. government program or a program for which the federal or state government pays all or part of the cost. This Exclusion does not apply to health benefits plans for civilian employees or retired civilian employees of the federal or state government;
- received from an employer mutual association, trust, or a labor union's Dental or Medical department;
- for diseases contracted or injuries caused because of participation in war, declared or undeclared, voluntary participation in civil disobedience, or other such activities;
- for injuries or illnesses incurred as a result of your commission of, or attempt to commit a crime;
- 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;
- amounts above the Allowable Charge for a service;

- self-administered services or self-care;
- self-help training; and
- biofeedback, neurofeedback, and related diagnostic tests.

Your coverage does not include benefits for the following **Skilled Nursing Facility** Stays:

- treatment of psychiatric conditions and senile deterioration;
- a private room unless it is Medically Necessary; or
- Facility services during a temporary leave of absence from the Facility.

Your coverage does not include **subrogation**.

T

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

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

Your **Telemedicine** coverage does not include services for the following:

- audio-only telephone conversations;
- electronic mail message;
- Skype;
- facsimile transmission;
- reporting normal lab or other test results;
- requesting office Visits;
- getting answers to billing;
- insurance coverage;
- payment questions;
- requesting referrals;
- benefit Precertification; or
- Provider to Provider discussions.

V

Your Medical coverage does not include benefits for the following **vision services**, except vision services as covered under the **Wellness and Preventive Care Services** section.

- surgery to correct nearsightedness and/or farsightedness including keratoplasty and Lasik procedure;
- vision training and orthoptics;
- 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 in accordance with Anthem's Medical policy.

Exclusions for **routine vision** services, administered by Anthem's Blue View Vision, are listed here and within the body of this booklet. Check both places for a complete listing.

- Any Medical or surgical treatment of the eyes and any diagnostic testing. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery;
- prescription sunglasses of any type;
- services required by your employer in connection with employment or benefits that would be covered under worker's compensation;
- safety glasses and accompanying frames;
- orthoptics or vision training and any associated supplemental testing;
- any non-prescription lenses, eyeglasses, contacts, Plano lenses or lenses that have no refractive power; or
- any other vision services not specifically listed as covered in accordance with Anthem Blue View Vision policy.

W

Your Health Plan does not include benefits for services or supplies if they are for **work-related** injuries or diseases when the employer, or worker if self-employed, must provide benefits by federal, state, or local law or when that person's work-related health claims have been paid by the employer. This Exclusion applies even if you waive your right to payment under these laws and regulations or fail to comply with your employer's procedures to receive the benefits. It also applies whether or not the Covered Person reaches a settlement with his or her employer or the employer's insurer or self-insurance association because of the injury or disease.

BASIC PLAN PROVISIONS

1) The Department's Right to Change, End, and Interpret Benefits

Your Health Plan is sponsored by the Commonwealth of Virginia (State) and administered by the Department of Human Resource Management. The Department is authorized to, and reserves the right to, change or terminate Your Health Plan on behalf of the Commonwealth at any time. These retained rights extend, without limit, to all aspects of Your Health Plan, including benefits, eligibility for benefits, Provider networks, premiums, Copayments and contributions required of employees. The Department is also authorized and empowered to exercise discretion in interpreting the terms of Your Health Plan and such discretionary determination will be binding on all parties.

2) You and Your Provider

You have the right to select your own Provider of care. Services provided by an institutional Provider are subject to the rules and regulations of Your Health Plan. These include rules about admission, discharge, and availability of services. Neither the Plan Administrator, the State, nor The Local Choice Group guarantees admission or the availability of any specific type of room or kind of service. Neither the Plan Administrator, the State, nor The Local Choice Group will be responsible for acts or omissions of any Facility. Neither the Plan Administrator, the State, nor The Local Choice Group will be liable for the negligence, misconduct, malpractice, refusal or inability to render services, or any other failing of a Facility. Neither the Plan Administrator, the State, nor The Local Choice Group will be liable for breach of contract because of anything done, or not done, by a Facility.

Similarly, the Plan Administrator is obligated only to pay, in part, for the services of your professional Provider to the extent the services are covered. Neither the Plan Administrator, the State, nor The Local Choice Group guarantees the availability of a Provider's services. Neither the Plan Administrator, the State, nor The Local Choice Group will be responsible for acts or omissions of any Provider. Neither the Plan Administrator, the State, nor The Local Choice Group will be liable for the negligence, misconduct, malpractice, refusal or inability to render services, or any other failing of a Provider. Neither the Plan Administrator, the State, nor The Local Choice Group will be liable for breach of contract because of anything done, or not done, by a Provider. The same limitations apply to services rendered or not rendered by a Provider's employee.

You must tell the Provider that you are eligible for services. When you receive services, show Your Health Plan identification card. Show only your current card.

3) Privacy Protection and Your Authorization

Information may be collected from other people and facilities. This is done in order to administer your coverage. The information often comes from Medical care facilities and Medical professionals who submit claims for you. Collected information is disclosed to others only in accordance with the guidelines set forth in the Health Insurance Portability and Accountability Act (HIPAA) and in the Virginia Insurance Information and Privacy Protection Act.

When you apply for coverage under The Local Choice Health Benefits Program, you agree that the Plan Administrator may request any Medical information or other records from any source when related to claims submitted to the Plan Administrator for services you receive. By accepting coverage under The Local Choice Health Benefits Program, you authorize any individual, association, or firm which has diagnosed or treated your condition to furnish the

Plan Administrator with necessary information, records, or copies of records. This authorization extends to any person or organization which has any information or records related to the service received or to the diagnosis and treatment of your condition.

If the Plan Administrator asks for information and does not receive it, payment cannot be made. The claim will be processed only when the requested information or record has been received and reviewed.

Medical information is often highly confidential. You are entitled to review or receive only copies of Medical information which applies to you. But, subject to the above, a member may review copies of Medical records which pertain to enrolled dependent children under age 18 as allowed by law.

4) The Personal Nature of These Benefits (Assignment of Benefits)

Plan benefits are personal; that is, they are available only to you and your covered dependents. You may not assign (give to another person) your right to receive services or payment, except as provided in law. Prior payments to anyone will not constitute a waiver of or in any way restrict the Plan Administrator's right to direct future payments to you or any other individual or Facility, even if there has been an assignment of payment in the past. This paragraph will not apply to assignments made to dentists and oral surgeons.

You and the Plan Administrator agree that other individuals, organizations, and health care practitioners will not be beneficiaries of the payments provided under this contract. This explanation of services and payments available to you is not intended for anyone else's benefit. As such, no one else (except for your personal representative in case of your death or mental incapacity) may assert any rights described in this booklet or provided under Your Health Plan.

5) Proof of Loss

In many cases, the Facility or Provider will submit your claim to the Plan Administrator. However, the Plan Administrator cannot process claims for you unless there is satisfactory proof that the services you received are covered. In most cases, "satisfactory proof" is a fully itemized bill which gives your name, date of the service, cost of the service, and the diagnosis for the condition. In some cases, the Plan Administrator will need additional proof, such as Medical information or explanations. Your cooperation may be requested. Your claim cannot be processed until the needed information is received. All claims information and explanations submitted to the Plan Administrator must be in writing.

6) Timely Filing of Claims

No claim (proof of loss) will be paid if the Plan Administrator receives it more than 12 months after the end of the calendar year in which the services were received. There is an exception: Out-of-Network vision claims must be submitted to Blue View Vision within one year from the original date of service.

7) Payment Errors

Every effort is made to process claims promptly and correctly. If payments are made to you, or on your behalf, and the Plan Administrator finds at a later date the payments were incorrect, the Plan Administrator will pay any underpayment. Likewise, you must repay any overpayment. A written notice will be sent to the member if repayment is required.

8) Group Benefits Administrator and Other Plan Information

Your Group Benefits Administrator is the person appointed by your employer to assist you with your health care benefits. Your Group Benefits Administrator may also provide you information about your benefits. If there is a conflict between what your Group Benefits Administrator tells you and Your Health Plan, your benefits will, to the extent permitted by law, be determined on the basis of the language in this booklet. The Group Benefits Administrator is never the agent of the Plan Administrator.

The Plan Administrator may send communications intended for you to your Group Benefits Administrator. You may be provided with another booklet, brochure, employee communication, or other material which describes the benefits available under Your Health Plan. In the event of conflict between this type of information and Your Health Plan, your benefits will be determined on the basis of the language in this booklet.

9) Plan Administrator's Continuing Rights

On occasion, the Plan Administrator or the State may not insist on your strict performance of all terms of Your Health Plan. Failure to apply terms or conditions does not mean the Plan Administrator or the State waives or gives up any future rights it may have. The Plan Administrator or the State may later require strict performance of these terms or conditions.

10) Time Limits on Legal Actions and Limitation on Damages

No action at law or suit in equity may be brought against the Plan Administrator, the State, or The Local Choice Group in any matter relating to (1) Your Health Plan, (2) the Plan Administrator's performance or the State's performance under Your Health Plan; or (3) any statements made by an employee, officer, or director of the Plan Administrator, the State, or The Local Choice Group concerning Your Health Plan or the benefits available if the matter in dispute occurred more than one year ago.

In the event you or your representative sues the Plan Administrator, the State, The Local Choice Group, or any director, officer, or employee of the Plan Administrator, the State, or The Local Choice Group acting in a capacity as a director, officer, or employee, your damages will be limited to the amount of your claim for covered services. The damages will not exceed the amount of any claim not properly paid as of the time the lawsuit is filed. In no event will this contract be interpreted so that punitive or indirect damages, legal fees, or damages for emotional distress or mental anguish are available.

11) Services after Amendment of Your Health Plan

A change in Your Health Plan will change covered services available to you on the Effective Date of the change. This means that your coverage will change even though you are receiving covered services for an ongoing illness, injury, pregnancy-related condition, or if you may need more services or supplies in the future. There is only one exception. If you are an Inpatient on the day a change becomes effective, covered services your hospital provides you will not be changed for that admission. In this case, the change in your coverage will be effective immediately after your discharge for that admission.

12) Misrepresentation

A member's coverage can be canceled by the Plan Administrator, the State, or the The Local Choice Group if it finds that any information needed to accept the member or process a claim was deliberately misrepresented by, or with the knowledge of, the member. The Plan Administrator, the State, or The Local Choice Group may also cancel coverage for any other family members enrolled with the member. When false

or misleading information is discovered, the Plan Administrator, the State, or The Local Choice Group may cancel coverage retroactive to the date of misrepresentation.

Examples of misrepresentation include:

- adding a dependent that does not meet eligibility definitions of the health plan; or
- failure to remove an ineligible person (i.e. ex-spouse).

13) Non-Payment of Monthly Charges

If you are required to pay monthly charges to maintain coverage, and such charges are late, the Plan Administrator has the right to suspend payment of your claims. The Plan Administrator will not be responsible for claims for any period for which full monthly charges have not been paid. If your monthly charges remain unpaid 31 days from the date due, the State may instruct the Plan Administrator to cancel your coverage.

14) Death of a Member

Coverage will end for a dependent enrolled with the Member if the Member dies unless continuation of coverage is properly elected and maintained pursuant to Extended Coverage rules. Coverage for the dependent will end on the last day of the month in which the Member's death occurs unless the local employer elects, in advance, a one month option for continued survivor coverage. If this option is elected, coverage for surviving dependents of a deceased member will continue until the end of the month following the date of the member's death. Full premium, with continued employer and dependent contribution, is required. Survivors must participate and no plan changes are permitted. The one month additional survivor benefit is a local employer option and must be elected annually by the local employer. The Local Choice Group will notify the Plan Administrator of the death so that conversion privileges may be extended to the dependents.

15) Divorce

Coverage will end for the enrolled spouse of a member on the last day of the month in which the final divorce decree is granted unless continuation of coverage is properly elected and maintained. Refer to the **Eligibility, Enrollment and Changes** section of this booklet.

16) End of Dependent Coverage

When a dependent is no longer eligible for coverage, the dependent must notify the Plan Administrator in writing that he/she wishes to continue coverage under another contract or certificate rather than through The Local Choice Health Benefits Program. Conversion privileges for the dependent will be extended if the Plan Administrator receives notice within 31 days after the end of the month in which the dependent ceased to be eligible for coverage under The Local Choice Health Benefits Program.

ELIGIBILITY, ENROLLMENT AND CHANGES

Who Is Eligible for Coverage

Full-time and part-time employees may be eligible to participate. Retirees and surviving dependents of retired employees may also be eligible for coverage as described later in this section.

You may choose your type of membership as follows:
Employee/retiree single – to cover yourself only
Employee/retiree plus one – to cover yourself and one eligible dependent
Family – to cover yourself and two or more eligible dependents

The Following Dependents Are Eligible for Coverage Under Your Health Plan

You must provide proof of a dependent's eligibility anytime you add a dependent to Your Health Plan.

The Employee's Legal Spouse
The marriage must be recognized as legal in the Commonwealth of Virginia.

Ex-spouses are not eligible, even with a court order.

Documentation required:
- photocopy of certified or registered marriage certificate, and
- photocopy of the top portion of the first page of the employee's most recent Federal Tax Return that shows the dependent listed as "Spouse".

  Note: All financial information and Social Security Numbers can be redacted.

The Employee's Children
Under the health benefits program, the following eligible children may be covered to the end of the calendar year in which they turn age 26 (the Plan's Limiting Age). The age requirement may be waived for adult incapacitated children.

Natural or Adopted Children and Children Placed for Adoption

Documentation required:
- photocopy of birth certificate or legal adoptive agreement showing employee's name.

  Note: If this is a legal pre-adoptive agreement, it must be reviewed and approved by the Office of Health Benefits.

Stepchildren
A stepchild is the natural or legally adopted child of the participant's legal spouse. Such marriage must be recognized by the Commonwealth of Virginia.

Documentation required:
- photocopy of birth certificate (or adoption agreement) showing the name of the employee's spouse; and

- photocopy of certified or registered marriage certificate showing the employee's name and the name of the dependent's parent; and
- photocopy of the top portion of the first page of the employee's most recent Federal Tax Return that shows the dependent's parent listed as "Spouse".

  Note: All financial information and Social Security Numbers can be redacted.

Other Female or Male Child
An unmarried child in which a court has issued a final order naming the employee (and/or the employee's legal spouse) to assume sole, permanent custody, if the following are met:

- principal place of residence is with the employee;
- child is a member of the employee's household;
- child receives over one half of his or her support from the employee;
- custody is awarded prior to the child's 18th birthday; and
- the custody is not shared between anyone other than the employee and the employee's legal spouse.

Documentation required:
- photocopy of the Final Court Order granting sole, permanent custody with presiding judge's signature.

Exception for Grandchildren
If the employee (or employee's legal spouse) shares custody of their grandchild with their dependent who is under the age of 18 (and is the parent of the grandchild), then the grandchild may also be covered if:

- the grandchild, the minor dependent (who is the parent), and the employee's legal spouse (if applicable) all live in the same household as the employee;
- both dependents are unmarried;
- both dependents receive over one-half of their support from the employee;
- the custody is not shared between anyone other than the employee, the employee's legal spouse and their minor dependent.

The minor dependent must meet all of the eligibility requirements of a dependent child. Once the minor dependent turns 18, the employee or employee's legal spouse (if applicable) must receive sole, permanent custody of the grandchild for the child to remain eligible.

Documentation required:
- photocopy of the grandchild's birth certificate showing the name of the minor dependent as the parent of the grandchild;
- photocopy of the birth certificate (or adoptive agreement) for the minor dependent showing the name of the employee; and
- photocopy of the Final Court Order with presiding judge's signature.

Incapacitated Dependents
Adult children who are incapacitated due to a physical or mental health condition, as long as the child was covered by Your Health Plan and the incapacitation existed prior to the termination of coverage due to the child attaining the Plan's Limiting Age. The employee must make written application, along with proof of incapacitation, prior to the child reaching the Plan's Limiting Age. Such extension of coverage must be approved by Your Health Plan and is subject to periodic review. Should Your Health Plan find that the child no longer meets the criteria for coverage as

an incapacitated child, the child's coverage will be terminated at the end of the month following notification from Your Health Plan to the enrollee.

The child must live full-time with the employee as a member of the employee's household, not be married, and be dependent upon the employee for financial support. In the cases where the natural or adoptive parents are living apart, living with the other parent will satisfy the condition of living with the employee. Furthermore, the support test is met if either the employee or other parent or combination of the employee and other parent provide over one-half of the child's financial support.

Adult incapacitated children of new employees who have been continuously incapacitated may also be covered provided that:

- the enrollment form is submitted within 30 days of hire;
- the child has been covered continuously as an incapacitated dependent on a parent's group employer coverage since the incapacitation first occurred or as a Medicaid/Medicare recipient (Note: supporting documentation must be submitted);
- the incapacitation commenced prior to the child attaining the limiting age of Your Health Plan;
- the enrollment form must be accompanied by a letter from a physician explaining the nature of the incapacitation, date of onset and certifying that the dependent is not capable of financial self-support. This extension of coverage must be approved by Your Health Plan; and
- other Medical certification and eligibility documentation is provided, as needed.

Adding Adult Incapacitated Dependents as a Qualifying Mid-Year Event

Adult Incapacitated Dependents that are enrolled as an incapacitated dependent on a parent's group employer coverage, or in Medicare or Medicaid, may be enrolled in The Local Choice Health Benefits Program with a consistent qualifying mid-year event (as defined by the Department of Human Resource Management) if the dependent remained continuously incapacitated, eligibility rules are met, required documentation is provided and the administrator for the plan in which the employee is enrolled approves the adult dependent's condition as incapacitating. Eligibility rules require that the incapacitated dependent live full-time at home, is not married, and receives over one-half of his or her financial support from the employee.

Documentation required:

- photocopy of birth certificate or legal adoptive agreement showing the employee's name
- evidence that the dependent has been covered continuously as an incapacitated dependent on a parent's group employer coverage, or covered under Medicaid or Medicare, since the incapacitation first occurred;
- proof that the incapacitation commenced prior to the dependent attaining age 26;
- an enrollment form adding the dependent within the timeframe allowed by the group's flexible benefits document and no later than 60 days of the qualifying mid-year event accompanied by a letter from a physician explaining the nature of the incapacitation, date of onset and certifying that the dependent is not capable of financial self-support. Additionally the plan reserves the right to request additional Medical information and to request an independent Medical examination; and
- other Medical certification and eligibility documentation, as needed.

If an incapacitated dependent leaves the Local Choice Health Benefits Program and later wants to return, the review will take into consideration whether or not the same disability was present prior to them reaching the Plan's Limiting Age of 26 and continued throughout the period that the child was not covered by The Local Choice Health Benefits Program. If the dependent was

capable of financial self-support as an adult, and then backtracked into disability, the disability is considered to have begun after the Plan's Limiting Age and the person cannot be added to The Local Choice Health Benefits Program.

Adult Incapacitated Dependents are not eligible to join the plan during the annual open enrollment period.

When a child loses eligibility, coverage terminates at the end of the month in which the event that causes the loss of eligibility occurs.

Dependent Coverage for Retirees Not Eligible for Medicare
The Local Choice Group may elect but is not required to offer Key Advantage coverage to retirees not eligible for Medicare and their eligible dependents. Retirees who meet the Local Employer's and The Local Choice Group's eligibility standards and enroll within 31 days of starting retirement or losing eligibility for coverage as an active employee may be eligible for coverage under the health plan until they become eligible for Medicare (either due to age or disability). Dependent eligibility for the retiree group does not differ from that of active employees. However, dependents of retirees must not be Medicare eligible if they are to continue coverage in Key Advantage. See your Group Benefits Administrator for more information about eligibility for coverage in the retiree group.

Who Is Not Eligible For Coverage
There are certain categories of persons who may not be covered as dependents under the program. These include dependent siblings, grandchildren, nieces, and nephews except where the criteria for "other children" are satisfied. Parents, grandparents, aunts, and uncles and any other individuals not specifically listed as eligible in this section are not eligible for coverage regardless of dependency status.

You cannot cover a person as a dependent unless that person is a U.S. citizen, U.S. resident alien, U.S. national, or a resident of Canada or Mexico. However, there is an exception for certain adopted children. If you are a U.S. citizen or U.S. national who has legally adopted a child who is not a U.S. citizen, U.S. resident alien, or U.S. national, you may cover the child, if the child lived with you as a member of your household all year. This exception also applies if the child was lawfully placed with you for legal adoption.

Participants who enroll or fail to remove ineligible persons within the timeframe allowed by the group's flexible benefits document and no later than 60 days from the dependent's loss of eligibility may be excluded from the program for a period of up to three years. In addition, the participant will be responsible for claims paid in error and will be unable to reduce health benefits membership except during open enrollment or with a consistent qualifying mid-year event.

Enrollment and Changes

There are only certain times when you may enroll yourself and eligible dependents in a health benefits plan, or change your type of membership or plan. You must remove anyone who is no longer eligible for the plan within the timeframe allowed by the group's flexible benefits document and no later than 60 days from the loss of eligibility. You risk suspension from the health benefits program for up to three years if you cover individuals who do not qualify.

When Newly Eligible
You have up to 30 calendar days to enroll from your date of hire or date you become eligible for health benefits. The 30-day countdown period begins on the first day of employment or eligibility. If the enrollment action is received within the 30 calendar day time frame, coverage will be effective the first of the month following the date of employment or eligibility. If that date is the first day of the month, your coverage begins that day.

There is no discretion allowed in this area. Coverage will always be effective as described above. In no case will coverage begin before your first day of employment or eligibility. In addition, once you have submitted a valid election that election is binding and may not change after it takes effect. A probationary or waiting period before the Effective Date may be applied if uniform for all employees. Waiting periods may not exceed 90 days.

Retirement
The Local Choice Group (TLC) may elect but is not required to offer coverage to retirees not eligible for Medicare and their eligible dependents. Retirees must meet the Local Employer's and The Local Choice Group's (TLC) eligibility standards. TLC eligibility will mirror the retirement requirements of the Virginia Retirement System (VRS) whether or not the local employer group participates with VRS. Those requirements are: At least 55 years of age, have at least five (5) years of service with the participating employer or at least 50 years of age with at least ten (10) years of service with the local employer.

If the Local Employer offers Retiree coverage, retirees eligible for coverage in the plan but not eligible for Medicare, may elect coverage under the health plan if they enroll in the retiree group within 31 days of their retirement date. Eligible retirees who did not participate in the health plan as an active employee prior to retirement may enroll in single coverage at the time of retirement if they do so within 31 days of their retirement date. New retirees may not increase membership based on retirement but they may increase membership with the occurrence of a separate qualifying mid-year event that would allow the increase or at open enrollment.

Non-Medicare eligible retiree group participants may make membership and plan changes upon the occurrence of a qualifying mid-year event and at open enrollment. Retiree group participants may reduce membership level at any time, and the Effective Date will be the first day of the month after the notification is received by their Group Benefits Administrator. However, retirees who cancel their own coverage may not return to the program.

During Open Enrollment
Health benefits open enrollment occurs in the spring (certain school groups may elect a fall open enrollment period) for employees and retirees who are not eligible for Medicare. Open enrollment is your opportunity to make changes in your health benefits plan and/or type of membership. The benefits and premiums associated with your open enrollment elections will be effective July 1 (or October 1 for certain school groups). Open enrollment elections are irrevocable once the open enrollment period ends.

Qualifying Mid-Year Events (Changes Outside Open Enrollment)
You may make membership and plan changes during the Plan Year that are based on qualifying mid-year events. You must submit your change no later than 60 calendar days of the event or in the time frame allowed by the group's flexible benefits document. The countdown begins on the day of the event. Normally the change will be effective the first of the month after the date the submission of an election change is received. There are two exceptions to the Effective Date. These include HIPAA Special Enrollment Provisions and Terminations

required by the plan which are covered later in this section. In addition, once you have submitted a valid election that election is binding and may not change after it takes effect.

The following events permit a change outside open enrollment. You may change a benefit election when a valid qualifying mid-year event occurs, but only if your change is made on account of, and corresponds with, a qualifying mid-year event that affects your own, your spouse's or your dependent's eligibility for coverage. The employer's flexible benefit document must also permit these changes. If you have questions about these events, contact your Group Benefits Administrator.

- Birth, Adoption, or Placement for Adoption*
- Child Covered under Your Health Plan Lost Eligibility
- Death of Child
- Death of Spouse
- Divorce
- Employment Change – Beginning a Leave Without Pay
- Employment Change – Full-time to Part-time
- Employment Change – Part-time to Full-time
- Employment Change –Returning from a Leave Without Pay
- Enroll in a Qualified Health plan through the Marketplace Exchange under the Affordable Care Act (ACA)
- Gained Eligibility under Medicare or Medicaid
- HIPAA Special Enrollment
- Judgment, Decree, or Order to Add Child
- Judgment, Decree, or Order to Remove Child
- Lost Eligibility under Governmental Plan
- Lost Eligibility under Medicare or Medicaid
- Marriage
- Move Affecting Eligibility for Health Care Plan
- Other Employer's Open Enrollment or Plan Change Spouse or Child Gained Eligibility under Their Employer's Plan
- Spouse or Child Lost Eligibility under Their Employer's Plan

*Placement, or being placed, for adoption means the assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child's adoption. The child's placement for adoption with such person ends upon the termination of such legal obligation. An agreement for full or partial support of a child will constitute a legal obligation only if the obligation is enforceable in a court of competent jurisdiction, which depends on the facts and circumstances associated with the agreement. The employee must be party to the support agreement and the agreement must extend beyond the obligation to provide Medical coverage.

HIPAA Special Enrollment

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, under a *HIPAA Special Enrollment* you may be able to enroll yourself and your dependents in this plan if:

- you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards your or your dependents' other coverage). However, you must request enrollment no later than 60 days of the event or in the time frame allowed by the group's flexible benefits document, that your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).
- you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and all eligible dependents. However, you must

request enrollment no later than 60 days of the event or in the time frame allowed by the group's flexible benefits document, of the marriage, birth, adoption or placement for adoption.
- you or your dependent lose coverage in Medicaid or the State Children's Health Insurance
- Program (SCHIP) and you request coverage under the plan no later than 60 days from the time your coverage ends; or
- you or your dependent become eligible for a Medicaid or SCHIP premium assistance subsidy and you request coverage under the plan no later than 60 days from the date your eligibility is determined.

Special Enrollment Provisions for Birth, Adoption or Placement for Adoption
An exception to prospective changes is health plan coverage for newborns, adopted children, and those children placed for adoption. In these events, health plan coverage will be retroactive to the date of birth, adoption or placement for adoption. Full premium for that month is required.

However, in some cases, employees or retiree group participants may make the health plan coverage election on a prospective basis. If the employee or retiree group participant can provide documentation of coverage for the month of birth, adoption or placement for adoption, then their coverage in The Local Choice Health Plan can be effective the first of the month following receipt of the enrollment action.

Terminations Required by the Plan
You can only provide coverage for family members who meet the health plan's eligibility definition. Terminations required by the plan due to loss of eligibility would include events such as divorce, or when a child loses eligibility. In cases where there is a loss of dependent eligibility, the Effective Date of the change is based on the date of the event.

You still have no later than 60 calendar days or the timeframe allowed by the group's flexible benefits document, to submit the enrollment form to remove the ineligible dependent. However, the change is effective the end of the month in which the dependent lost eligibility. Once the dependent has been removed from coverage, your membership may be reduced. If the membership is reduced, the Local Employer needs to refund premiums paid for the higher membership following the dependent's loss of eligibility. While you still need to take action, if you do not make an election change within the 60 day time frame or the timeframe allowed by the group's flexible benefits document, then the current membership level will be maintained, the family member will be removed from coverage at the end of the month during which the loss of eligibility event took place, and there will be no refund of premium. In addition, the participant will be responsible for claims paid for the ineligible dependent.

After Coverage Ends

Coverage ends on the last day of the month during which eligibility ceases. When a Covered Person ceases to be eligible or the required premiums are not paid, the Covered Person's coverage will end.

Examples of when a Covered Person's eligibility may cease include:
- when you leave your job with the employer, or change from full-time to part-time employment and the employer does not offer coverage to part-time employees;
- when a dependent child reaches the end of the year in which the child turns 26;
- in the case of an incapacitated dependent, when the child is no longer incapacitated or meets the eligibility requirements; or

- in the case of your spouse, when you and your spouse divorce (Note: Coverage will end for the enrolled spouse of a member on the last day of the month in which the final divorce decree is granted unless continuation of coverage is properly reported, elected and maintained).

Benefits will not be paid for charges you incur after your coverage ends. There are two exceptions. If you are an Inpatient the day your coverage ends, your Facility and Professional Provider coverage will continue until you are discharged to the extent that services were covered prior to the end of coverage. This would include all types of confinement: Acute Care Facility, rehabilitation and Skilled Nursing Facility. All services must continue to meet Medical necessity guidelines. Also, Other Covered Services such as rental of Medical Equipment (durable), will be provided for a limited time for a condition for which you received covered services before your coverage ended. The time will be the shorter of when you become covered under any other group coverage, or the end of the Plan Year your coverage ends, or a period equal to the time you were enrolled under Your Health Plan.

When You Become Eligible for Medicare
You may remain enrolled under this Health Plan as long as you continue working and meet the other eligibility requirements. See your Group Benefits Administrator for more information. Contact the nearest Social Security Office or go to **www.ssa.gov** when you or a family member becomes eligible for Medicare (due to age or disability) if you need more information or would like to enroll. Medicare benefits are secondary to benefits payable under the Local Choice plan for individuals who have coverage in TLC as a result of their own or their spouse's active employment status with TLC since TLC has 20 or more employees.

The TLC plan is required to offer to their active employees who are age 65 or over, or otherwise eligible for Medicare, and their Medicare-eligible dependents the same coverage as they offer to employees and their dependents who are not eligible for Medicare (except when Medicare eligibility is due to End Stage Renal Disease and the coordination period is exhausted, Medicare becomes primary to the TLC plan, even if the coverage is due to active employment). Medicare beneficiaries may terminate active employee coverage within 31 days of Medicare entitlement or reject employer plan coverage in which case they may retain Medicare as their primary coverage. When Medicare is primary payer, employers cannot offer such active employees or their dependents secondary coverage for items and services covered by Medicare. Employers may not sponsor or contribute to individual Medigap or Medicare Supplement policies for beneficiaries who have coverage based on current employment status.

Participating retirees, survivors and their dependents who become eligible for Medicare, whether due to age or disability may not remain in a Key Advantage Plan. A Medicare supplemental plan through TLC may be available to Medicare eligible retirees. To receive maximum benefits, they must enroll in Medicare Parts A, B and D immediately upon eligibility. Failure to enroll in Parts A and B may result in coverage deficits since the program's Medicare-coordinating plans will not pay any part of a claim that would have been covered by Medicare had the participant been properly enrolled in Medicare. TLC Medicare supplemental plans do not cover Outpatient Prescription Drugs. **If it is determined that a retiree group participant is eligible for Medicare but has continued coverage in a non-Medicare coordinating plan, primary claim payments made in error may be retracted and the participant or group billed for outpatient prescription drug usage.**

For more information about coordination of benefits with Medicare, call **800-MEDICARE** or go to **www.Medicare.gov**.

Continuing Coverage When Eligibility Ends
If you and/or your covered family members lose coverage due to certain qualifying events, as described in this section, you may be eligible for Extended Coverage under the Public Health Services Act.

GENERAL NOTICE OF EXTENDED COVERAGE RIGHTS

This notice generally explains Extended Coverage/COBRA, which is a temporary extension of health plan coverage. This notice explains continuation of coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.

The right to COBRA continuation coverage for employees of private employers was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). These rights are also provided to employees of state and local government employers under the continuation coverage provisions of the Public Health Service Act, which is referred to as Extended Coverage. Extended Coverage can become available to you and other members of your family when t group health coverage would otherwise end.

For more information about your rights and obligations under Your Health Plan and under the federal law, you should contact your Group Benefits Administrator.

You may have other options available to you when you lose group health coverage.
For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower Out-of-Pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is Extended Coverage (COBRA)?
Extended Coverage is a continuation of health plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, Extended Coverage must be offered to each person who is a "qualified beneficiary." You, your covered spouse, and your covered children may be qualified beneficiaries if coverage under Your Health Plan is lost because of the qualifying event. Under Your Health Plan, qualified beneficiaries who elect Extended Coverage must pay the full cost unless it runs concurrently with another benefit that provides a contribution toward the premium cost.

If you are an employee, you may become a qualified beneficiary if you lose your coverage under Your Health Plan because of either one of the following qualifying events:

- your hours of employment are reduced (this includes periods of leave without pay, and any reduction of hours resulting in loss of coverage and/or loss of or change in the terms and conditions of the employer contribution toward the cost of coverage; or
- your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee or retiree group participant, you will become a qualified beneficiary if you lose your coverage under Your Health Plan because of any one of the following qualifying events:

- your spouse dies;
- your spouse's hours of employment are reduced;
- your spouse's employment ends for any reason other than his or her gross misconduct;
- your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- you become divorced from your spouse.

Your covered children will become qualified beneficiaries if they lose coverage under Your Health Plan because of the following qualifying events:

- the parent/employee/retiree dies;
- the parent/employee's hours of employment are reduced;
- the parent/employee's employment ends for any reason other than his or her gross misconduct;
- the parent/employee/retiree becomes entitled to Medicare benefits (Part A, Part B, or both);
- the parents become divorced, resulting in loss of dependent eligibility; or
- the child stops being eligible for coverage under the plan as a "covered child".

NOTE: Coverage that is terminated in anticipation of a qualifying event (for example, a divorce) is disregarded when determining whether the event results in a loss of coverage. If termination occurs under this condition but notification of the qualifying event is received from the employee, qualified beneficiary or a representative within 60 days of the date coverage would have been lost due to the qualifying event, Extended Coverage must be made available and effective on the date coverage would have been lost due to the event, but not before.

When is COBRA continuation coverage available?

Your Group Benefits Administrator will offer Extended Coverage automatically (without requiring notice) to qualified beneficiaries if the qualifying event is:

- End of employment; or
- Reduction in hours of employment; or
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce of the employee and spouse; a covered child's loss of eligibility as a covered child), you must notify your Group Benefits Administrator in writing within 60 days of the date coverage would be lost due to that qualifying event by submitting the following information:

- The type of qualifying event (e.g., divorce, loss of dependent child's eligibility--including reason for the loss of eligibility);
- The name of the affected qualified beneficiary (e.g., spouse's and/or covered child's/children's name/s);
- The date of the qualifying event;
- Documentation to support the occurrence of the qualifying event (e.g., final divorce decree, etc.);
- The written signature of the notifying party;
- If the address of record is incorrect, an address for mailing the Election Notice.

Failure to provide timely notice of these qualifying events will result in loss of eligibility for continuation coverage. One notice will cover all affected qualified beneficiaries. Notice will be considered furnished when mailed/postmarked or, in the case of hand delivery, the date it is received by your Group Benefits Administrator.

How Is COBRA continuation coverage provided?

Once the qualifying even has occurred or, if necessary, the Group Benefits Administrator receives notice that a qualifying event has occurred, Extended Coverage will be offered to each

qualified beneficiaries. Each qualified beneficiary will have an independent right to elect Extended Coverage. Covered employees may elect Extended Coverage on behalf of an eligible spouse, and parents may elect Extended Coverage on behalf of their children.

Extended Coverage is a temporary continuation of coverage that generally lasts for up to 18 months due to employment termination or reduction of hours of work. Divorce or loss of eligibility as a covered child allows for up to 36 months of continuation coverage. If a second (36-month) qualifying event occurs and is reported within 60 days of the date coverage would be lost due to that event, you may be eligible to receive a maximum of 36 months of coverage measured from the initial loss of coverage.

Additional ways that an 18-month period of continuation coverage can be extended are:

1) **Disability extension of 18-month period of continuation coverage**
   If you or anyone in your family who is covered under the plan is determined by Social Security to be disabled and you notify the Extended Coverage/COBRA Administrator within the specified time limits described below, you and your entire family may be entitled to get up to an additional 11 months of continuation coverage (a maximum of 29 months). The disability must have started at some time before the 60th day of continuation coverage and must last at least until the end of the 18-month initial period of continuation coverage. Your Group Benefits Administrator must receive notification of the disability determination within 60 days of either:
   - the date of the disability determination;
   - the date of the qualifying event;
   - the date on which coverage would be lost due to the qualifying event; or,
   - the date on which the qualified beneficiary is informed of the obligation to provide the disability notice (e.g., through this General Notice); **AND**
   - within the first 18 months of Extended Coverage.

   Notification must be presented to the Group Benefits Administrator in writing and include the following information:
   - The name of the disabled qualified beneficiary;
   - The date of the determination;
   - Documentation from the Social Security Administration to support the determination;
   - The written signature of the notifying party (qualified beneficiary or representative); and
   - if the address of record is incorrect, a correct mailing address.

NOTE: While the cost of Extended Coverage is the full (employee plus employer contribution) cost of the coverage plus a 2% administrative fee, the cost of coverage during the disability extension increases to include a 50% administrative fee.

2) **Second qualifying event extension of 18-month period of continuation coverage**
   If your family experiences another qualifying event while receiving 18 months of Extended Coverage, the spouse and dependent children in your family can get up to 18 additional months of continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Group Benefits Administrator in the format and time frame specified below. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee/former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), divorced from the covered spouse, or the covered dependent child ceases to be eligible under Your Health Plan, but only if the event would have caused the spouse or dependent child to lose coverage under Your Health Plan had the first qualifying event not occurred.

Written notification must be given within 60 days of the date coverage would have been lost due to the second qualifying event and should include the following information:

- the type of second qualifying event (e.g., divorce, loss of dependent eligibility);
- the name of the affected qualified beneficiary (e.g., spouse and/or dependent child);
- the date of the second qualifying event;
- documentation to support the occurrence of the second qualifying event (e.g., final divorce decree);
- the written signature of the notifying party; and
- if the address of record is incorrect, a correct mailing address.

Failure to furnish timely and complete notification of the second qualifying event or disability determination will result in loss of additional Extended Coverage eligibility. Notice will be considered furnished when mailed or, in the case of hand delivery, on the date it is received by your Group Benefits Administrator.

Separate guidelines apply to continuation coverage under the provisions of the Uniform Services Employment and Re-employment Rights Act of 1994 (USERRA). If these provisions apply to you, see your Group Benefits Administrator for more information.

If You Have Questions
Questions concerning Your Health Plan or your Extended Coverage rights should be addressed to your Group Benefits Administrator.

Keep Your Plan Informed of Address Changes
In order to protect your family's rights, you should keep the Group Benefits Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Group Benefits Administrator.

Plan Contact Information
For information about Extended Coverage, initial notification of qualifying events, and initial enrollment, contact your Group Benefits Administrator.

To make changes to Extended Coverage after initial enrollment, contact your Group Benefits Administrator.

For more information about the Marketplace, visit **www.HealthCare.gov**.

Employee/Retiree Privacy Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Background: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires health plans to notify plan participants and beneficiaries about its policies and practices to protect the confidentiality of their health information. This document is intended to satisfy HIPAA's notice requirement with respect to all health information created, received, or maintained by The Local Choice Plan (TLC), and the agents acting on its behalf, as the group health plan (the "Plan"). For purposes of HIPAA the covered entity is The Local Choice plan.

The Plan needs to create, receive, and maintain records that contain health information about you to administer the Plan and provide you with health care benefits. This notice describes the Plan's health information privacy policy with respect to your health plan including any or all of the following plans; Medical, Prescription Drug, Dental, Behavioral Health and Vision plans. The notice tells you the ways the Plan may use and disclose health information about you, describes your rights, and the obligations the Plan has regarding the use and disclosure of your health information. However, it does not address the health information policies or practices of your health care Providers.

The Local Choice' ***Pledge Regarding Health Information Privacy***

The privacy policy and practices of the Plan protects confidential health information that identifies you or could be used to identify you and relates to a past, present, or future physical or mental health condition or the past, present or future payment of your health care expenses. This individually identifiable health information is known as "protected health information" (PHI). Your PHI will not be used or disclosed without a written authorization from you, except as described in this notice or as otherwise permitted by federal and state health information privacy laws.

Privacy Obligations of the Plan

The Plan is required by law to:

- make sure that health information that identifies you is kept private;
- give you this notice of the Plan's legal duties and privacy practices with respect to health information about you;
- notify you if you are affected by a breach of unsecured PHI; and
- follow the terms of the notice that is currently in effect.

How the Plan May Use and Disclose Health Information About You

The following are the different ways the Plan may use and disclose your PHI:

For Treatment. The Plan may disclose your PHI to a health care Provider who renders treatment on your behalf. For example, if you are unable to provide your medical history as the result of an accident, the Plan may advise an emergency room physician about the types of prescription drugs you currently take.

For Payment. The Plan may use and disclose your PHI so claims for health care treatment, services, and supplies you receive from health care Providers may be paid according to the

Plan's terms. For example, the Plan may receive and maintain information about surgery you received to enable the Plan to process a hospital's claim for reimbursement of surgical expenses incurred on your behalf.

For Health Care Operations. The Plan may use and disclose your PHI to enable it to operate or operate more efficiently or make certain all of the Plan's participants receive their health benefits. For example, the Plan may use your PHI for case management or to perform population-based studies designed to reduce health care costs. In addition, the Plan may use or disclose your PHI to conduct compliance reviews, audits, actuarial studies, and/or for fraud and abuse detection. The Plan may also combine health information about many Plan participants and disclose it to employees working under the Secretaries of Administration and Finance, and members of the General Assembly of Virginia in summary fashion so they can decide what coverages the Plan should provide. The Plan will remove information that identifies you from health information disclosed to these individuals so it may be used without these individuals learning who the specific participants are. The Plan may also use or disclose your PHI for underwriting and premium rating purposes, but the Plan does not use or disclose your PHI that is genetic information for underwriting purposes.

To The Commonwealth of Virginia. The Plan may disclose your PHI to designated Department of Human Resource Management personnel so they can carry out their Plan-related administrative functions, including the uses and disclosures described in this notice. Such disclosures will be made only to the Director of the Department of Human Resource Management and/or the Director of the Office of Contracts and Finance. These individuals will protect the privacy of your health information and ensure it is used only as described in this notice or as permitted by law. Unless authorized by you in writing, your health information: (1) may not be disclosed by the Plan to any other Commonwealth employee or department and (2) will not be used by the Commonwealth for any employment-related actions and decisions or in connection with any other employee benefit plan sponsored by the Commonwealth of Virginia.

To a Business Associate. Certain services are provided to the Plan by third party administrators known as "business associates." For example, the Plan may input information about your health care treatment into an electronic claims processing system maintained by the Plan's business associate so your claim may be paid. In so doing, the Plan will disclose your PHI to its business associate so it can perform its claims payment function. However, the Plan will require its business associates, through contract, to appropriately safeguard your health information.

Treatment Alternatives. The Plan may use and disclose your PHI to tell you about possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services. The Plan may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.

Individual Involved in Your Care or Payment of Your Care. The Plan may use or disclose to your family member, other relative, your close personal friend, or other person you identify, PHI directly relevant to such person’s involvement in your health care or payment related to your care. The Plan may use or disclose your PHI to notify a family member, your personal representative, or another person responsible for your care, about your location, condition, or death. In these situations, when you are present and not incapacitated, they will either (1) obtain your agreement; (2) provide you with an opportunity to disagree to the use or disclosure; or (3) using reasonable judgment, infer from the circumstances that you do not object to the disclosure. If you are not present, or you cannot agree or disagree to the use or disclosure due to incapacity or emergency

circumstances, the Plan may use professional judgment to determine that the disclosure is in your best interests and disclose PHI relevant to such person's involvement in your care, payment related to your health care, or notification purposes. If you are deceased, the Plan may disclose PHI to such individuals involved in your care or payment for your health care prior to your death the PHI that is relevant to the individual's involvement, unless you have previously instructed the Plan otherwise.

As Required by Law. The Plan will disclose your PHI when required to do so by federal, state, or local law, including those that require the reporting of certain types of wounds or physical injuries.

Special Use and Disclosure Situations

The Plan may also use or disclose your PHI under the following circumstances:

Lawsuits and Disputes. If you become involved in a lawsuit or other legal action, the Plan may disclose your PHI in response to a court or administrative order, a subpoena, warrant, discovery request, or other lawful due process.

Law Enforcement. The Plan may release your PHI if asked to do so by a law enforcement official, for example, to identify or locate a suspect, material witness, or missing person or to report a crime, the crime's location or victims, or the identity, description, or location of the person who committed the crime.

Workers' Compensation. The Plan may disclose your PHI to the extent authorized by and to the extent necessary to comply with workers' compensation laws or other similar programs.

Military and Veterans. If you are or become a member of the U.S. armed forces, the Plan may release medical information about you as deemed necessary by military command authorities.

To Avert Serious Threat to Health or Safety. The Plan may use and disclose your PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person.

Public Health Risks. The Plan may disclose health information about you for public health activities. These activities include preventing or controlling disease, injury or disability; reporting births and deaths; reporting child abuse or neglect; or reporting reactions to medication or problems with medical products or to notify people of recalls of products they have been using.

Health Oversight Activities. The Plan may disclose your PHI to a health oversight agency for audits, investigations, inspections, and licensure necessary for the government to monitor the health care system and government programs.

Research. Under certain circumstances, the Plan may use and disclose your PHI for medical research purposes.

National Security, Intelligence Activities, and Protective Services. The Plan may release your PHI to facilitate specified government functions related to: (1) intelligence, counterintelligence and other national security activities authorized by law; (2) the provision of protective services to the President of the United States, members of the U.S. government or foreign heads of state, or to conduct special investigations; and (3) correctional institutions and other law enforcement custodial situations.

Organ and Tissue Donation. If you are an organ donor, the Plan may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank to facilitate organ or tissue donation and transplantation.

Coroners, Medical Examiners, and Funerals Directors. The Plan may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. The Plan may also release your PHI to a funeral director, as necessary, to carry out his/her duty.

Assist Victims of Abuse, Neglect, or Domestic Violence. The Plan may, under certain circumstances, disclose PHI about you if you are reasonably believed to be a victim of abuse, neglect, or domestic violence to a government authority, including a social service or protective services agency, authorized by law to receive such reports.
Certain Government-Approved Research Activities. The Plan may use or disclose PHI about you to research as provided under the Privacy Rule.

Breach of Unsecured PHI
You must be notified in the event of a breach of unsecured PHI that affects you. A "breach" is the acquisition, access, use, or disclosure of PHI in a manner that compromises the security or privacy of the PHI. If you are affected by a breach of unsecured PHI you must receive a notice of the breach as soon as possible and no later than 60 days after the discovery of the breach.

Your Rights Regarding Health Information About You

Your rights regarding the health information the Plan maintains about you are as follows:

Right to Inspect and Copy. You have the right to inspect and copy your PHI, including your PHI maintained in an electronic format. This includes information about your plan eligibility, claim and appeal records, and billing records, but does not include psychotherapy notes. If your PHI is available in an electronic format, you may request access electronically.

To inspect and copy health information maintained by the Plan, submit your request in writing to the Privacy Official. The Plan may charge a fee for the cost of copying and/or mailing your request. But, this fee must be limited to the cost of labor involved in responding to your request if you requested access to an electronic health record. In limited circumstances, the Plan may deny your request to inspect and copy your PHI. Generally, if you are denied access to health information, you may request a review of the denial.

Right to Amend. If you feel that health information the Plan has about you is incorrect or incomplete, you may ask the Plan to amend it. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, send a detailed request in writing to the Plan Administrator. You must provide the reason(s) to support your request. The Plan may deny your request if you ask the Plan to amend health information that was: accurate and complete, not created by the Plan; not part of the health information kept by or for the Plan; or not information that you would be permitted to inspect and copy.

Right to An Accounting of Disclosures. You have the right to request an "accounting of disclosures," including a disclosure involving an electronic health record. This is a list of disclosures of your PHI that the Plan has made to others, except those necessary to carry out health care treatment, payment, or operations (Note: does not apply to electronic health records); disclosures made to you; or in certain other situations.

To request an accounting of disclosures, submit your request in writing to the Privacy Official. Your request must state a time period, which may not be longer than six years prior to the date the accounting was requested (three years in the case of a disclosure involving an electronic health record).

Right to Request Restrictions. You have the right to request a restriction on the health information the Plan uses or disclosures about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information the Plan discloses about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that the Plan not use or disclose information about a surgery you had.

To request restrictions, make your request in writing to the Plan Administrator. You must advise us: (1) what information you want to limit; (2) whether you want to limit the Plan's use, disclosure, or both; and (3) to whom you want the limit(s) to apply.

Note: ***The Plan is not required to agree to your request.***

Right to Request Confidential Communications. You have the right to request that the Plan communicate with you about health matters in a certain way or at a certain location. For example, you can ask that the Plan send you explanation of benefits (EOB) forms about your benefit claims to a specified address.

To request confidential communications, make your request in writing to the Plan Administrator. The Plan will make every attempt to accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Disclosure of PHI to a Personal Representative. You may request that the Plan disclose your PHI to your personal representative. A personal representative is an individual you designate to act on your behalf and make decisions about your health care. If you want the Plan to disclose your PHI to your personal representative, submit a written statement giving the Plan permission to release your PHI to your personal representative and documentation that this individual qualifies as your personal representative under state law, such as a power of attorney. Submit this request in writing to the appropriate privacy contact listed below. The Plan may elect not to treat a person as your personal representation if (1) the Plan reasonably believes that you have been or may be subject to domestic violence, abuse or neglect by such person, or treating such person as your personal representative could endanger you; or (2) the Plan, using professional judgment, decides that it is not in your best interest to treat the person as your personal representative

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice, even if you received this Notice previously or agreed to receive this Notice electronically. You may write to the Plan Administrator to request a written copy of this notice at any time.

Changes to this Notice

The Plan reserves the right to change this notice at any time and to make the revised or changed notice effective for health information the Plan already has about you, as well as any information the Plan receives in the future. The Plan will provide a copy of the current notice to be posted in the Benefits Office of each employer at all times.

Complaints

If you believe your privacy rights under this policy have been violated, you may file a written complaint with the Plan Administrator at the address listed below. Alternatively, you may complain to the Secretary of the U.S. Department of Health and Human Services, generally, within 180 days of when the act or omission complained of occurred.

Note: **You will *not be penalized or retaliated against for filing a complaint.***

Other Uses and Disclosures of Health Information

Other uses and disclosures of health information not covered by this notice or by the laws that apply to the Plan will be made only with your written authorization. Your written authorization is also required for:

- Most uses or disclosures of psychotherapy notes (where appropriate);
- Uses or disclosures of your health information for marketing purposes. Marketing does not include communications, involving no financial remuneration, for certain treatment or health care operations purposes, such as communications about entities that participate in a health plan network, health plan enhancements or replacements, case management or care coordination, or contacting individuals about treatment alternatives; and
- Disclosures of PHI that are considered a sale

If you authorize the Plan to use or disclose your PHI, you may revoke the authorization, in writing, at any time. If you revoke your authorization, the Plan will no longer use or disclose your PHI for the reasons covered by your written authorization; however, the Plan will not reverse any uses or disclosures already made in reliance on your prior authorization.

Contact Information

If you have any questions about this notice, please contact:

The Local Choice Program
c/o The Department of Human Resource Management
101 North 14th Street, 12th Floor
Richmond, VA 23219
804-225-2131

Notice Effective Date: January 1, 2003, as revised effective September 23, 2013.

HIPAA Privacy Practices

Disclosure of Protected Health Information (PHI) to the Employer
(1) Definitions. Whenever used in this Article, the following terms shall have the respective meanings set forth below.

(a) Plan - means the “State and Local Health Benefits Programs.”
(b) Employer - means the local employer group.
(c) Plan Administration Functions - means administrative functions performed by the Employer on behalf of the Plan, excluding functions performed by the Employer in connection with any other benefit or benefit plan of the Employer.
(d) Health Information - means information (whether oral or recorded in any form or medium) that is created or received by a health care Provider, health plan (as defined by the Health Insurance Portability and Accountability Act of 1996, subsequently referred to as HIPAA, in 45 CFR Section 160.103), employer, life insurer, school or university, or health care clearinghouse (as defined by HIPAA in 45 CFR Section 160.103) that relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.
(e) Individually Identifiable Health Information - means Health Information, including demographic information, collected from an individual and created or received by a health care Provider, health plan, employer, or health care clearinghouse that identifies the individual involved or with respect to which there is a reasonable basis to believe the information may be used to identify the individual involved.
(f) Summary Health Information - means information that summarizes the claims history, expenses, or types of claims by individuals for whom the Employer provides benefits under the Plan, and from which the following information has been removed: (1) names; (2) geographic information more specific than state; (3) all elements of dates relating to the individual(s) involved (e.g., birth date) or their Medical treatment (e.g., admission date) except the year; all ages for those over age 89 and all elements of dates, including the year, indicative of such age (except that ages and elements may be aggregated into a single category of age 90 and older); (4) other identifying numbers, such as Social Security, telephone, fax, or Medical record numbers, email addresses, VIN, or serial numbers; (5) facial photographs or biometric identifiers (e.g., finger prints); and (6) any information the Employer does not have knowledge of that could be used alone or in combination with other information to identify an individual.
(g) Protected Health Information ("PHI") means Individually Identifiable Health Information that is transmitted or maintained electronically, or any other form or medium.

(2) The Plan, and the agents acting on its behalf, may disclose Summary Health Information to the Employer if the Employer requests such information for the purpose of obtaining premium bids for providing health insurance coverage under the Plan or for modifying, amending, or terminating the Plan.

(3) The Plan, and the agents acting on its behalf, will disclose PHI to the Employer only in accordance with HIPAA in 45 CFR Section 164.504(f) and the provisions of this Section.

(4) The Plan hereby incorporates the following provisions (a) through (j) to enable it to disclose PHI to the Employer and acknowledges receipt of written certification from the Employer that the Plan has been so amended. Additionally, the Employer agrees:

(a) not to use or further disclose PHI other than as permitted in Section (4) or as required by law;
(b) to ensure that any of its agents or subcontractors to whom it provides PHI received from the Plan agree to the same restrictions and conditions;
(c) not to use or disclose PHI for employment-related actions or in connection with any other benefit or employee benefit plan;
(d) to report to the Plan any use or disclosure of the information that is inconsistent with the permitted uses and disclosures in Section (4);
(e) to make PHI available to individuals in accordance with HIPAA in 45 CFR Section 164.524;
(f) to make PHI available for individuals' amendment and incorporate any amendments in accordance with HIPAA in 45 CFR Section 164.526;
(g) to make the information available that will provide individuals with an accounting of disclosures in accordance with HIPAA in 45 CFR Section 164.528;
(h) to make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan and its agents available to the Department of Health and Human Services upon request; and
(i) if feasible, to return or destroy all PHI received from the Plan that the Employer maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Employer will limit further its uses and disclosures of the PHI to those purposes that make the return or destruction of the information infeasible.
(j) to ensure that adequate separation between the Plan and the Employer, as required by HIPAA in 45 CFR Section 164.504(f), is established and maintained.

(5) The Plan will disclose PHI only to the following employees or classes of employees:

- Director, Department of Human Resource Management
- Director of Finance, Department of Human Resource Management
- Staff members, Office of Health Benefits

Access to and use of PHI by the individuals described above shall be restricted to Plan Administration Functions that the Employer performs for the Plan. Such access or use shall be permitted only to the extent necessary for these individuals to perform their respective duties for the Plan.

(6) Instances of noncompliance with the permitted uses or disclosures of PHI set forth in this Section by individuals described in Section (5) shall be considered “failure to comply with established written policy” (a Group II offense) and must be addressed under the Commonwealth of Virginia’s Policy 1.60, Standards of Conduct Policy. The appropriate level of disciplinary action will be determined on a case-by-case basis by the agency head or designee, with sanctions up to or including termination depending on the severity of the offense, consistent with Policy 1.60.

(7) A health insurance issuer, HMO or third party administrator providing services to the Plan is not permitted to disclose PHI to the Employer except as would be permitted by the Plan in this Article and only if a notice is maintained and provided as required by HIPAA in 45 CFR Section 164.520.

Important Notice About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the TLC Health Benefits Program and about your options under Medicare's prescription drug coverage. Should you become eligible for Medicare, this information can help you decide whether or not you want to join a Medicare drug plan. If you consider joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. **The Local Choice Health Benefits Program has determined that the prescription drug coverage offered by the Key Advantage Plans, the Kaiser Permanente HMO and the High Deductible Health Plan (all plans offered to eligible active employees) are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, and drop your current TLC coverage as an active employee (based on the policies and procedures of the Department of Human Resource Management, TLC and applicable law), be aware that you and your dependents will not be able to return to this coverage except with the occurrence of a consistent Qualifying Mid-Year Event or at Open Enrollment. The TLC Health Benefits Program does not offer a medical plan to active employees that excludes prescription drug coverage. Consequently, you must either maintain full coverage under the available plans (including prescription drug coverage) or terminate coverage completely. You do not have the option of terminating only the prescription drug benefit under your TLC plan. Please contact your Group Benefits Administrator if you need additional information.
At the time an Enrollee and/or covered dependent becomes eligible for Medicare, he/she/they may keep TLC plan coverage based on active employment or may

terminate coverage under the TLC Health Benefits Program based on that event if termination is completed within 31 days of eligibility for Medicare. However, once coverage has been terminated, neither the employee nor the dependent may re-enroll in the program except upon the occurrence of a consistent Qualifying Mid-Year Event (for example, loss of Medicare coverage) or at Open Enrollment. An eligible dependent may not enroll unless the employee is enrolled. If an active employee or the covered dependent of an active employee has both TLC coverage and Medicare, except in limited circumstances, the TLC plan will pay primary before Medicare.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with the TLC Health Benefits Program and do not join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll for January 1.

For more information about this notice or your current prescription drug coverage, contact your Group Benefits Administrator. NOTE: You will receive this Notice annually, prior to the Medicare Part D Annual Coordinated Election Period and at any time there is a change in the TLC Health Benefits Program's prescription drug coverage. You also may request a copy from your Group Benefits Administrator at any time.

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Commonwealth of Virginia's Health Benefits Programs Nondiscrimination Notice

The State and Local Health Benefits Programs of the Department of Human Resource Management (the "Plan"), sponsored by the Commonwealth of Virginia (the "Commonwealth") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (such as large print, audio, accessible electronic formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Office of Health Benefits Programs.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Office of Health Benefits Programs
Department of Human Resource
Management 101 North 14th Street – 13th
Floor Richmond, Virginia 23219-3657
Please mark the envelope - **Confidential**

To use email, send your complaint to **appeals@dhrm.virginia.gov**

To use facsimile, fax your complaint to **804-786-0356**.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Office of Health Benefits Program is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

OTHER FEDERAL NOTICES

Genetic Information Nondiscrimination Act of 2008 (GINA)

Effective January 1, 2010, GINA prohibits health coverage and employment discrimination against a Plan participant based on his or her genetic information. Genetic information generally includes family Medical history and information about an individual's and his or her family members' genetic tests and genetic services.

Under GINA, group health plans and health insurers providing group health plan coverage cannot use genetic information with respect to eligibility, premiums or contribution amounts. They also cannot request, require or purchase genetic information prior to a person's enrollment in a health care plan or request or require genetic testing of an individual for underwriting purposes. The availability of genetic testing and the results of any genetic testing you undergo will be treated as confidential, as required by GINA and the Health Insurance Portability and Accountability Act of 1996.

The Newborns' and Mothers' Health Protection Act

Maternity hospital Stays under the Plan will be covered for a minimum of 48 hours following a vaginal delivery, or 96 hours for a cesarean section delivery. These minimums are set by a federal law called The Newborns' and Mothers' Protection Act. However, the Plan may pay for a shorter Stay if the attending Provider (physician, nurse midwife or physician's assistant) discharges the mother or newborn earlier, after consulting with the mother.

Other provisions of this law:

- The level of benefits for any portion of the hospital Stay that extends beyond 48 hours (or 96 hours) cannot be less favorable to the mother or newborn than the earlier portion of the Stay.
- The Plan cannot require Precertification for a Stay of up to 48 or 96 hours, as described above – although Stays beyond those times must be precertified if the Plan includes a Precertification requirement.

Women's Health and Cancer Rights

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1988 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and the reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other Medical and surgical benefits provided under this plan. Your Health Plan is required to provide you with a notice of your rights under WHCRA when you enroll in the health plan, and then once each year.

USERRA Military Leave

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) allows qualified employees to continue their enrollment in the plan for up to 24 months when they are called to active duty for more than 31 days.

You may continue plan coverage during your military leave until the earlier of:

- 24 months (terms are similar to COBRA); or
- the date you fail to return to work as outlined by USERRA.

If you do not continue coverage for you or your family members during your leave and you return to work:

- you and your family members will again be covered on the first of the month following the date you return to work from your military leave, if you apply at that time (this requires you to return to work as outlined by USERRA);
- any eligibility waiting period not completed earlier will not be credited during your leave. You will be given credit for the time you were covered under the plan before your military leave, as well as credit for any/all of the 24-month continuation period, when elected. You are responsible for paying the employee cost for coverage during a military leave. If you fail to make timely payments, as outlined in your billing statement, your coverage will be terminated. You must pay the billed amount in full; you cannot defer payments until you return to work.

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