Anthem HealthKeepers

Individual and family health benefit plans for Virginia

Benefit Snapshot

Core, Essential and Preferred plans

Benefit Snapshot

Below is a listing of our plan choices, including a sample of commonly used benefits and how they are covered under each plan. Each plan name has a unique four-letter code at the end. When filling out an application, make sure the entire plan name on the application (including the four letters) matches the plan you want to apply for.

If you need more information about a certain benefit that is not listed here, please check with your HealthKeepers, Inc. (HealthKeepers) authorized representative. You can also view and compare plans on anthem.com.

Plan Name	Network Name	Calendar Year Deductible		Calendar Year Out-of-pocket Limit		Office Visit: Primary Care Doctor	Preventive Care	Retail Prescription Drug Coverage			
		Individual	Family	Individual	Family			Tier 1	Tier 2	Tier 3	Tier 4
Anthem HealthKeepers Core DirectAccess with HSA - cacd	Pathway Tiered Hospital	$3,750	$7,500	$6,200	$12,400	25% coinsurance	No cost to you	Deductible and 25% coinsurance applies	Deductible and 25% coinsurance applies	Deductible and 25% coinsurance applies	Deductible and 25% coinsurance applies
Anthem HealthKeepers Core DirectAccess - cabw	Pathway Tiered Hospital	$4,500	$9,000	$6,350	$12,700	$35 copay per visit for first 3 office visits, then deductible and 35% coinsurance applies	No cost to you	Deductible and 35% coinsurance applies	Deductible and 35% coinsurance applies	Deductible and 35% coinsurance applies	Deductible and 35% coinsurance applies
Anthem HealthKeepers Core DirectAccess with Child Dental - cdbw	Pathway Tiered Hospital	$4,500	$9,000	$6,350	$12,700	$35 copay per visit for first 3 office visits, then deductible and 35% coinsurance applies	No cost to you	Deductible and 35% coinsurance applies	Deductible and 35% coinsurance applies	Deductible and 35% coinsurance applies	Deductible and 35% coinsurance applies
Anthem HealthKeepers Core DirectAccess - caam	Pathway Tiered Hospital	$5,500	$11,000	$6,350	$12,700	$40 copay per visit for first 2 office visits, then deductible and 25% coinsurance applies	No cost to you	Deductible and 25% coinsurance applies	Deductible and 25% coinsurance applies	Deductible and 25% coinsurance applies	Deductible and 25% coinsurance applies
Anthem HealthKeepers Core DirectAccess with HSA - caas	Pathway Tiered Hospital	$6,000	$12,000	$6,350	$12,700	15% coinsurance	No cost to you	Deductible and 15% coinsurance applies	Deductible and 15% coinsurance applies	Deductible and 15% coinsurance applies	Deductible and 15% coinsurance applies
Anthem HealthKeepers Essential DirectAccess - cbky	Pathway Tiered Hospital	$1,500	$3,000	$5,500	$11,000	$35 copay per visit for first 3 office visits, then deductible and 30% coinsurance applies	No cost to you	$15 copay	$40 copay	Deductible and 30% coinsurance applies	Deductible and 30% coinsurance applies
Anthem HealthKeepers Essential DirectAccess - cbjs	Pathway Tiered Hospital	$2,250	$4,500	$6,350	$12,700	$35 copay, unlimited	No cost to you	$15 copay	$40 copay	Deductible and 20% coinsurance applies	Deductible and 20% coinsurance applies
Anthem HealthKeepers Essential DirectAccess - cbfs	Pathway Tiered Hospital	$2,600	$5,200	$6,000	$12,000	$35 copay per visit for first 3 office visits, then deductible and 20% coinsurance applies	No cost to you	$15 copay	$40 copay	Deductible and 20% coinsurance applies	Deductible and 20% coinsurance applies
Anthem HealthKeepers Essential DirectAccess - cbau	Pathway Tiered Hospital	$3,350	$6,700	$5,500	$11,000	$45 copay, unlimited	No cost to you	$15 copay	$40 copay	Deductible and 15% coinsurance applies	Deductible and 15% coinsurance applies
Anthem HealthKeepers Preferred DirectAccess - ccam	Pathway Tiered Hospital	$750	$1,500	$3,500	$7,000	$30 copay, unlimited	No cost to you	$15 copay	$40 copay	Deductible and 20% coinsurance applies	Deductible and 20% coinsurance applies
Anthem HealthKeepers Preferred DirectAccess with Child Dental - cdda	Pathway Tiered Hospital	$750	$1,500	$3,500	$7,000	$30 copay, unlimited	No cost to you	$15 copay	$40 copay	Deductible and 20% coinsurance applies	Deductible and 20% coinsurance applies

Preventive care services consist of services recommended by the United States Preventive Services Task Force, including well-child care, immunizations, PSA screenings, Pap tests, mammograms and more.

Tiered hospitals: Our plans offer a Tiered network. In-network hospitals are split into two categories, Tier 1 and Tier 2. You will pay a lower cost share for hospitals in Tier 1. You can find out what tier a hospital is in through our Find a Doctor tool at anthem.com.

Emergency room services have a higher cost share. For additional details on this and other covered services, go to anthem.com

All plans available with optional bariatric surgery coverage for an additional premium. For more information contact your HealthKeepers authorized representative.

Anthem. HealthKeepers

Get help today!

Call your HealthKeepers authorized representative or visit us online at anthem.com where you can view and compare plan options.

This document is only a brief summary of benefits and services. Our plans have exclusions, limitations and terms under which the plan/policy may be continued in force or discontinued. For more complete details including what's covered and what isn't:

- See the coverage details document included with this brochure.
- Call your HealthKeepers authorized representative.
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For more information on how to access a Summary of Benefits and Coverage (SBC), please visit www.healthcare.gov and enter SBC in the search field.

The health plans described within this document are not eligible for a premium tax credit subsidy.

This piece is only one part of your information kit. This piece refers to Policy form # VA_HMHS(1/14). Schedule of benefits forms VA_SB_BRZ_3750_0RUT_(1/14), VA_SB_BRZ_4500_0RUR_(1/14), VA_SB_BRZ_4500_PD_0RV3_(1/14), VA_SB_BRZ_5500_0RUM_(1/14), VA_SB_BRZ_6000_0RUP_(1/14), VA_SB_SLV_1500_0RVN_(1/14), VA_SB_SLV_2250_0RVH_(1/14), VA_SB_SLV_2600_0RVC_(1/14), VA_SB_SLV_3350_0RV7_(1/14), VA_SB_GLD_750_0RWD_(1/14), VA_SB_GLD_750_PD_0RWH_(1/14) and rider form VA_Bariatric_(1/14).

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Coverage Details for Virginia

Anthem HealthKeepers

Things you need to know before you buy...

***Anthem HealthKeepers Core DirectAccess, Anthem HealthKeepers Core DirectAccess with Child Dental, Anthem HealthKeepers Core DirectAccess with HSA, Anthem HealthKeepers Essential DirectAccess, Anthem HealthKeepers Preferred DirectAccess, Anthem HealthKeepers Preferred DirectAccess with Child Dental, Anthem HealthKeepers Catastrophic DirectAccess**

Before choosing a health benefit plan, please review the following information along with the other materials enclosed.

Eligibility

Subscriber

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

1. Be a United States citizen or national; or
2. Be a lawfully present non-citizen for the entire period for which coverage is sought; and
3. Be a legal resident of Virginia;
4. Be under age 65;
5. Submit proof satisfactory to HealthKeepers, Inc. (HealthKeepers) to confirm dependent eligibility;
6. Agree to pay for the cost of premium that HealthKeepers requires;
7. Reveal any coordination of benefits arrangements or other health benefit arrangements for the applicant or dependents as they become effective;
8. Not be incarcerated (except pending disposition of charges);
9. Not be entitled to or enrolled in Medicare Parts A/B and/or D;
10. Not be covered by any other group or individual health benefit plan.

For purposes of eligibility, the service area is the area in which you:

1. Reside, intend to reside (including without a fixed address); or
2. The area in which you are seeking employment (whether or not currently employed); or
3. Have entered without a job commitment.

Dependents

To be eligible for coverage to enroll as a dependent, you must be listed on the enrollment form completed by the subscriber, meet all dependent eligibility criteria and be:

1. The subscriber's legal spouse.
2. The subscriber's domestic partner as determined eligible by the Exchange.
3. The subscriber's or the subscriber's spouse's children, including stepchildren, newborn and legally adopted children under age 26.
4. Children under age 26 for whom the subscriber or the subscriber's spouse is a legal guardian.

Eligibility will be continued past the age limit only for those already enrolled dependents who cannot work to support themselves by reason of intellectual or physical disability. These dependents must be allowed as a federal tax exemption by the subscriber or subscriber's spouse. The dependent's disability must start before the end of the period he or she would become ineligible for coverage. The Plan must certify the dependent's eligibility. The Plan must be informed of the dependent's eligibility for continuation of coverage within 30 days after the dependent would normally become ineligible. You must notify us if the dependent's tax exemption status changes and if he or she is no longer eligible for continued coverage.

The Plan may require the subscriber to submit proof of continued eligibility for any enrolled child. Your failure to provide this information could result in termination of a child's coverage.

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

Any foster child who is eligible for benefits provided by any governmental program or law will not be eligible for coverage under your Evidence of Coverage unless required by the laws of this State.

Open Enrollment

An annual open enrollment period is provided for enrollees. Individuals may enroll in a plan, and members may change plans at that time.

Effective dates for open enrollment period:

The earliest effective date for the annual open enrollment period is the first day of the following benefit calendar year – if not defined. The actual effective date is determined by the date we receive a complete application with the applicable premium payment. Effective date for the annual open enrollment period is the first day of the following month if receipt of application and premium is between the 1st and 15th of the month. If receipt of application and premium is after the 15th of the month, your effective date will be the first day of the month following plus one additional month (example: application with premium receipt is January 20, your effective date is March 1).

Special Enrollment

A special enrollment period is a period during which a member or an enrollee who experiences certain qualifying events or changes in eligibility may enroll in a plan, outside of the annual open enrollment period.

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

Qualifying Events:

- Involuntary loss of minimum essential coverage for any reason other than fraud, intentional misrepresentation of a material fact or failure to pay premium;
- Loss of minimum essential coverage due to dissolution of marriage;
- Marriage;
- Adoption or placement for adoption; and
- Birth.

Newborn and Adopted Child Coverage

A newborn dependent may be covered from the moment of birth and a dependent placed with you for adoption is covered from the date of placement. Coverage for newborns will continue beyond the 31 days, provided the subscriber with other than family coverage submits through the Plan a form to add the child under the subscriber's Evidence of Coverage. The form must be submitted along with the additional premium, if applicable, within 60 days after the birth of the child. Failure to notify the Plan and pay any applicable premium during this 31 day period will result in no coverage for the newborn or adopted child beyond the first 31 days. A child will be considered adopted from the earlier of: (1) the moment of placement for adoption; or (2) the date of an entry of an order granting custody of the child to you. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption.

Adding a Child due to Award of Guardianship

If a subscriber or the subscriber's spouse files an application for an appointment of guardianship for a child, an application to cover the child under the subscriber's Evidence of Coverage must be submitted to HealthKeepers within 60 days of the date of the appointment of guardianship. Coverage will be effective on the date the appointment of guardianship is awarded by the court.

Qualified Medical Child Support Order

If you are required by a Qualified Medical Child Support Order or court order, as defined by applicable state or federal law, to enroll your child under your Evidence of Coverage, and the child is otherwise eligible for the coverage, HealthKeepers will permit your child to enroll under your Evidence of Coverage, and we will provide the benefits of your Evidence of Coverage in accordance with the applicable requirements of such order.

A child's coverage under this provision will not extend beyond any dependent age limit. Any claims payable under your Evidence of Coverage will be paid, at HealthKeepers' discretion, to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. We will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to us directly.

Effective Date of Coverage

The earliest effective date for the annual open enrollment period is the first day of the following benefit calendar year – if not defined. The actual effective date is determined by the date we receive a complete application with the applicable premium payment. Effective date for the annual open enrollment period is the first day of the following month if receipt of application and premium is between the 1st and 15th of the month. If receipt of application and premium is after the 15th of the month, your effective date will be the first day of the month following plus one additional month (example: application with premium receipt is January 20, your effective date is March 1).

Effective dates for special enrollment periods:

1. In the case of birth, adoption or placement for adoption, coverage is effective on the date of birth, adoption, or placement for adoption; and
2. In the case of marriage, or in the case where an individual loses minimum essential coverage, coverage is effective on the first day of the following month after your application is received.

Effective dates for loss of minimum essential coverage includes loss of eligibility for coverage as a result of:

1. Legal separation or divorce;
2. Cessation of dependent status, such as attaining the maximum age;
3. Death of an employee;
4. Termination of employment;
5. Reduction in the number of hours of employment; or
6. Any loss of eligibility for coverage for any of the following:
   - Individual who no longer resides, lives or works in the Plan's service area,
   - A situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits,
   - A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual,
   - Termination of employer contributions, and
   - Exhaustion of COBRA benefits.

Effective dates for loss of minimum essential coverage does not include termination or loss due to:

1. Failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or
2. Situations allowing for a rescission such as fraud or intentional misrepresentation of material fact.

Guaranteed Renewable

Coverage under your Evidence of Coverage is guaranteed renewable at your discretion. You may renew your Evidence of Coverage by payment of the renewal premium by the end of the grace period of the premium due date, provided the following requirements are satisfied:

1. Eligibility criteria continues to be met;
2. There are no fraudulent or intentional misrepresentations of material fact on the application or under the terms of this coverage, subject to the incontestability provision;
3. Membership has not been terminated by HealthKeepers under the terms of your Evidence of Coverage; and
4. Membership has not been rescinded by HealthKeepers.

HMO Providers

An HMO is a medical group, HMO physician, hospital, skilled nursing facility, pharmacy, or any other duly licensed institution or health professional who has Evidence of Coverage with the HMO or its designee to provide covered services to members. A list of HMO providers is made available to each subscriber prior to enrollment. A current list may be obtained from the HMO upon request and may be seen by visiting the HMO's website page at anthem.com. The list shall be revised by the HMO from time to time as the HMO deems necessary.

How to Find a Provider in the Network

There are three ways you can find out if a provider or facility is in the network for this Plan. You can also find out where they are located and details about their license or training.

- See your Plan's directory of in-network providers at anthem.com, which lists the doctors, providers, and facilities that participate in this Plan's network.
- Call Customer Service to ask for a list of doctors and providers that participate in this Plan's network, based on specialty and geographic area.
- Check with your doctor or provider.

If you need help choosing a doctor who is right for you, call the Customer Service number on the back of your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

Tier 1 and Tier 2 Hospitals

We have designated certain hospitals as participating in Tier 1 or Tier 2. Tier 1 hospitals have lower costs to the member. Tier 2 hospitals are more costly. While these hospitals are contracted with us, we make no representation on the relative quality of the services. When a member goes to an out-of-network hospital, there is no agreement on the cost of the service and the member is responsible for the entire amount the provider charges.

Below are examples of what criteria is used to determine whether a hospital was allocated to Tier 1 or Tier 2. In communities where there was only one hospital, these hospitals were allocated to Tier 1:

- Total share of payments by region of the Commonwealth
- The number of admissions per hospital and region
- The average length of stay per hospital
- The percentage of admissions over our contractual threshold
- The current case mix adjusted case rate by hospital and by region.
- The effective hospital discount inclusive of patient pay
- The percentage of claims paid on stop loss by hospital and hospital system
- The average charge increase by hospital and hospital system
- The hospital efficiency ratio based on Virginia Health Information reported actual length of stay divided by expected length of stay.

Outpatient Hospital Services

These are services provided in the hospital's outpatient department, or, if medically necessary, in the hospital's emergency room. We cover:

- Services and supplies used to diagnose or treat injuries resulting from an accident (including follow-up care);
- Services and supplies used to diagnose or treat the sudden onset of a severe emergency medical condition; and
- Services and supplies related to, and provided at the same time as a covered outpatient surgical services. Examples include:
    1. Anesthesia and its related supplies; and
    2. Operating and recovery room use.

Outpatient Care for an Inpatient from another Hospital

The ancillary services listed under the Inpatient Hospital Services provision of this section are covered at a different hospital location if the facility where you are an inpatient cannot provide the medically necessary service you need.

Requesting Approval for Benefits

To receive full benefits for covered inpatient hospitalization services you, a friend, a family member, your provider or facility must call us to receive admission approval for the proposed service.

Prior Authorization: In-network providers must obtain Prior Authorization in order for you to get benefits for certain services. Prior Authorization criteria will be based on many sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. We may decide that a service that was prescribed or asked for is not medically necessary if you have not first tried other medically necessary and more cost effective treatments.

If you have any questions about the information in this section, you may call the Customer Service phone number on the back of your Member Identification Card.

Types of Requests

- **Precertification** – A required review of a service, treatment or admission for a benefit coverage determination which must be done before the service, treatment or admission start date. For emergency admissions, you, your authorized representative or doctor must tell us within 48 hours of the admission or as soon as possible within a reasonable period of time. For labor / childbirth admissions, precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time.
- **Predetermination** – An optional, voluntary Prospective or Continued Stay Review Request for a benefit coverage determination for a service or treatment. We will check your coverage to find out if there is an exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to decide whether the service meets the definition of medical necessity under this coverage or is experimental/investigative as that term is defined in your coverage.
- **Post Service Clinical Claims Review** – A Retrospective Review for a benefit coverage determination to decide the medical necessity or experimental/investigative nature of a service, treatment or admission that did not need precertification and did not have a predetermination review performed. Medical reviews are done for a service, treatment or admission in which we have a related clinical coverage guideline and are typically initiated by us.

Typically, in-network providers know which services need Precertification and will get any Precertification or ask for a Predetermination when needed. Your primary care physician (PCP) and other in-network providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering provider, facility or attending doctor will get in touch with HealthKeepers to ask for a Precertification or Predetermination review ("requesting provider"). HealthKeepers will work with the requesting provider for the Precertification request. However, you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

Your Rights and Responsibilities

As a member, you have certain rights and responsibilities to help make sure that you get the most from this Plan. It helps you know what you can expect from your overall health care benefit experience and become a smarter health care consumer.

You have the right to:

- Speak freely and privately with your doctors and other health professionals about all health care options and treatment needed for your condition, no matter what the cost or whether it is covered under your Plan.
- Work with your doctors in making choices about your health care.
- Be treated with respect and dignity.
- Privacy of your personal health information, as long as it follows State and Federal laws and our privacy policies.
- Get information about our company and services, and our network of doctors and other health care providers.
- Get more information about your Rights and Responsibilities and give us your thoughts and ideas about them.
- Give us your thoughts and ideas about any of the rules of this Plan and in the way it works.
- Make complaints or appeal about: our organization, any benefit or coverage decisions we make, your coverage, or care received.
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future; and the right to have your doctor tell you how that may affect your health now and in the future.
- Get all of the most up-to-date information about the cause of your illness, your treatment and what may result from that illness or treatment from a doctor or other health care professional. When it seems that you will not be able to understand certain information, that information will be given to someone else that you choose.

You have the responsibility to:

- Treat all doctors, health care professionals and staff with courtesy and respect.
- Keep all scheduled appointments with your health care providers and call their office if you have a delay or need to cancel.
- Read and understand, to the best of your ability, all information about your health benefits or ask for help if you need it.
- To the extent possible, understand your health problems and work with your doctors or other health care professionals to make a treatment plan that you all agree on.
- Give us, your doctors and other health care professionals the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health coverage and insurance benefits you have in addition to your coverage with us.
- Tell your doctors or other health care professionals if you don't understand any care you are getting or what they want you to do as part of your care plan.
- Follow the care plan that you have agreed on with your doctors and other health care professionals.
- Follow all Plan rules and policies.
- Let our Customer Service department know if you have any changes to your name, address or dependents covered under your Plan.
- Pay your monthly premium. Your Evidence of Coverage is issued to the subscriber. The HMO agrees to provide covered services to you under the terms contained in your Evidence of Coverage. The subscriber must pay the applicable premium on or before the last business day of each month preceding the next month's coverage.

Exclusions

This list includes some of the more common services not covered by these plans:

- Acupuncture
- Allergy tests and treatment, except as spelled out in your Evidence of Coverage
- Artificial insemination, fertilization, infertility drugs or sterilization reversal
- Artificial and mechanical hearts
- Alternative or complementary medicine
- Bariatric surgery, unless optional benefit rider has been purchased.
- Benefits covered by Medicare or a governmental program
- Breast reduction or augmentation mammoplasty is excluded unless associated with breast reconstruction surgery following a medically necessary mastectomy resulting from cancer
- Care provided by a member of your family
- Care received in an emergency room that is not emergency care, except as specified in your Evidence of Coverage
- Charges incurred prior to the effective date of coverage or after the termination date of coverage
- Charges greater than the maximum allowable amount (charges exceeding the amount HealthKeepers recognizes for services)
- Comfort and/or convenience items
- Cosmetic surgery and/or treatment that's primarily intended to improve your appearance
- Custodial care
- Dental, except as described in your Evidence of Coverage
- Educational services, except as mandated
- Experimental or investigative treatment
- Non-chemical addictions such as gambling, spending, religious
- Nutritional and dietary supplements
- Over-the-counter drugs, devices or products
- Pharmacy except as spelled out in your Evidence of Coverage
- Routine foot care
- Sclerotherapy (a medical procedure used to eliminate varicose veins and spider veins)
- Services we determine aren't medically necessary
- Sex transformation surgery
- TMJ and Craniomandibular Joint Disorder. Covered services do not include fixed or removable appliance that involve movement or repositioning of the teeth repair of teeth (fillings) or prosthetics (crown, bridges, dentures).
- Vision except as described in your Evidence of Coverage
- Weight loss programs or treatment of obesity except as mandated
- Workers' compensation

Limitations

These services are limited as described below:

- Therapy services
  - Physical/Occupational therapy - 30 combined visits per member per year.
  - Speech therapy – 30 visits per member per year
- Chiropractic – 30 visits for manipulation per member per year
- Home health care – 100 visits per member per year
- Private duty nursing provided in a home care setting - 16 hours per member per year
- Skilled nursing facility – 100 days per stay

*All plans available with optional bariatric surgery coverage for an additional premium. For more information, contact your HealthKeepers authorized representative.

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Selecting health coverage is an important decision.

To assist you, we supply the following for the plans under consideration: Brochure, Benefit Snapshot, Coverage Details and Enrollment Application. If you did not receive one or more of these materials, please contact your HealthKeepers authorized representative to request them.

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