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

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

**RECOVERY OF OVERPAYMENTS**

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

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

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

acupuncture.

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

biofeedback therapy.

over the counter convenience and hygienic items. These include, but are not limited to, adhesive removers, cleansers, underpads, and ice bags.

cosmetic surgery or procedures, including complications that result from such surgeries and/or procedures. Cosmetic surgeries and procedures are performed mainly to improve or alter a person's appearance including body piercing and tattooing. However, a cosmetic surgery or procedure does not include a surgery or procedure to correct deformity caused by disease, trauma, or a previous therapeutic process. Cosmetic surgeries and/or procedures also do not include surgeries or procedures to correct congenital abnormalities that cause functional impairment. We will not consider the patient's mental state in deciding if the surgery is cosmetic.

no dental services are provided except for the following:
- medically necessary dental services resulting from an accidental injury. You must submit a plan of treatment from your dentist or oral surgeon for prior approval by the HMO. For an injury that occurs on or after our effective date of coverage, you must seek treatment within 60 days after the injury;
- the cost of dental services and dental appliances only when required to diagnose or treat an accidental injury to the teeth;
- the repair of dental appliances damaged as a result of an accidental injury to the jaw, mouth or face;
- dental services and appliances furnished to a newborn when required to treat medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia;
- dental services to prepare the mouth for radiation therapy to treat head and neck cancer; or
- covered general anesthesia and hospitalization services for children under the age of 5, covered persons who are severely disabled, and covered persons who have a medical condition that requires admission to a hospital or outpatient surgery facility. These services are provided when it is determined by a licensed dentist, in consultation with the covered persons' treating physician that such services are required to effectively and safely provide dental care.

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

educational or teacher services except in limited circumstances.

the following family planning services. These include:
- non-prescription contraceptive devices;
- services for artificial insemination;
- in vitro fertilization, or any other types of artificial or surgical means of conception, including drugs administered in connection with these procedures;

These services are excluded from your Anthem HealthKeepers plan.
The Ins And Outs Of Coverage

- drugs used to treat infertility; or
- reversals of sterilization and complications incidental to such procedures.

services for palliative or cosmetic foot care including:
- flat foot conditions;
- support devices, arch supports, foot inserts, orthopedic and corrective shoes that are not part of a leg brace and fittings, castings and other services related to devices of the feet;
- foot orthotics;
- subluxations of the foot;
- corns, 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.

routine hearing care (except as outlined in this brochure) or hearing aids (except cochlear implants) or exams for these devices.

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

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

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

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

medical equipment (durable), appliances, devices, and supplies that have both a non-therapeutic and therapeutic use. These include but are not limited to:
- exercise equipment;
- air conditioners, dehumidifiers, humidifiers, and purifiers;
- hypoallergenic bed linens, bed boards;
- whirlpool baths;

These services are excluded from your Anthem HealthKeepers plan.
- handrails, ramps, elevators, and stair glides;
- telephones;
- adjustments made to a vehicle;
- foot orthotics;
- changes made to a home or place of business; or
- repair or replacement of equipment you lose or damage through neglect.

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

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

the following mental health services and substance abuse services:

- inpatient stays for environmental changes;
- cognitive rehabilitation therapy;
- educational therapy;
- vocational and recreational activities;
- coma stimulation therapy;
- services for sexual deviation and dysfunction;
- treatment of social maladjustment without signs of a psychiatric disorder;
- remedial or special education services; or
- inpatient mental health treatments that meet the following criteria:
  - more than 2 hours of psychotherapy during a 24-hour period in addition to the psychotherapy being provided pursuant to the inpatient treatment program of the hospital;
  - group psychotherapy when there are more than 8 patients with a single therapist;
  - group psychotherapy when there are more than 12 patients with two therapists;
  - more than 12 convulsive therapy treatments during a single admission; or
  - psychotherapy provided on the same day of convulsive therapy.

services administered by non-network providers, except for emergencies or when authorized in advance by the Anthem HealthKeepers Medical Director. (This exclusion does not apply for the Point of Service plans, or for an annual routine eye exam which includes a $30 allowance for out-of-network providers.)
nutrition counseling and related services, except when provided as part of diabetes education.

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

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

paternity testing.

as part of the prescription drug benefit, coverage for:
- over the counter drugs;
- any per unit, per month quantity over the specified limit;
- drugs used mainly for cosmetic purposes;
- drugs that are experimental, investigational, or not approved by the FDA;
- cost of medicine that exceeds the allowable charge for that prescription;
- drugs for weight loss;
- stop smoking aids;
- therapeutic devices or appliances;
- injectable prescription drugs that are supplied by a provider other than a pharmacy;
- charges to inject or administer drugs;
- drugs not dispensed by a licensed pharmacy;
- drugs not prescribed by a licensed provider;
- any refill dispensed after one year from the date of the original prescription order;
- infertility medications;
- medications used to treat sexual dysfunction;
- medicine covered by workers’ compensation, Occupational Disease Law, state or government agencies; or medicine furnished by any other drug or medical service.

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

care from institutions and facilities that are licensed solely as residential treatment centers, or other non-skilled sub-acute inpatient settings.
services, supplies or devices if they are:
- not listed as covered;
- not prescribed, performed, or directed by a provider licensed to do so;
- received before the effective date or after a member’s coverage ends; or
- telephone consultations, charges for not keeping appointments, charges for completing claim forms or other such charges.

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

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

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

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

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

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

the following skilled nursing facility stays:
- treatment of psychiatric conditions and senile deterioration;
- facility services during a temporary leave of absence from the facility; or
- a private room unless it is medically necessary.

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

the following spinal manipulation and manual medical therapy services (chiropractic services):
- any treatment or service not authorized by American Specialty Health Network, Inc. (ASHN).
- any service or treatment not provided by an ASHN provider. (This exclusion does not apply for the Point of

These services are excluded from your Anthem HealthKeepers plan.
The Ins And Outs Of Coverage

- Services for examination and/or treatment of strictly non-neuromusculoskeletal disorders, or conjunctive therapy not associated with spinal or joint adjustment.
- Laboratory tests, x-rays, adjustments, physical therapy or other services not documented as medically necessary and appropriate, or classified as experimental or in the research stage.
- Diagnostic scanning, including Magnetic Resonance Imaging (MRI), CAT scans, and/or other types of diagnostic scanning; thermography.
- Educational programs, non-medical self-care or self-help, or any self-help physical exercise training, or any related diagnostic testing.
- Air conditioners, air purifiers, therapeutic mattresses, supplies or any other similar devices or appliances.
- Vitamins, minerals, nutritional supplements or any other similar type product.

The following therapies:
- Physical therapy, occupational therapy, or speech therapy to maintain or preserve current functions if there is no chance of improvement or reversal except for children under age 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.

The following vision services:
- Vision services or supplies unless needed due to eye surgery or accidental injury;
- Routine vision care and materials except as outlined in this brochure;
- Services for radial keratotomy and other surgical procedures to correct refractive defects such as nearsightedness, farsightedness and/or astigmatism. This type of surgery includes keratoplasty and Lasik procedure;
- Services for vision training and orthoptics;
- Tests associated with the fitting of contact lenses unless the contact lenses are needed due to eye surgery or to treat accidental injury;
- Sunglasses or safety glasses and accompanying frames of any type;
- Any non-prescription lenses, eyeglasses or contacts, or Plano lenses or lenses that have no refractive power;
- Any lost or broken lenses or frames;
- Any blended lenses (no line), oversize lenses, progressive multifocal lenses, photochromatic lenses, tinted lenses, coated lenses, cosmetic lenses or processes and UV-protected lenses;
- Services needed for employment or given by a medical department, clinic, or similar service provided or maintained by the employer or any government entity; or
- Any other vision services not specifically listed as covered.

Services or supplies if they are for work-related injuries or diseases when the employer must provide benefits by federal, state, or local law or when that person has been paid by the employer. 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.

These services are excluded from your Anthem HealthKeepers plan.
Anthem HealthKeepers is offered by HealthKeepers, Inc., a health maintenance organization. Throughout this brochure, the words "we," "us" and "our" are used. These words are referring to HealthKeepers, Inc. The term “service area” means the geographical locations and boundaries where we are licensed to provide health care coverage. The cities and counties in the service area are listed in the HealthKeepers, Inc. provider directory.

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

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

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