HealthKeepers

www.anthem.com

Customer service 855-580-1200

Anthem. HealthKeepers
Offered by HealthKeepers, Inc.

2022

A High Deductible Health Plan

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See FEHB Facts for details. This Plan is accredited. See Section 1.

Serving: The Northern and Eastern regions of Virginia.

Enrollment in this Plan is limited: You must live in our geographic service area to enroll. See Section 1 for requirements.

Enrollment codes for this Plan:

9V1 High Deductible Health Plan (HDHP) - Self Only
9V3 High Deductible Health Plan (HDHP) – Self Plus One
9V2 High Deductible Health Plan (HDHP) – Self and Family

IMPORTANT
- Rates: Back Cover
- Changes for 2022: Page 16
- Summary of Benefits: Page 92

Special Notice: This plan is being offered for the first time under the Federal Employees Health Benefits Program.

FEHB
Federal Employees
Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

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

Important Notice from HealthKeepers About Our Prescription Drug Coverage and Medicare

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

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

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

Please be advised

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

Medicare's Low Income Benefits

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

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

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

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Introduction

This brochure describes the benefits of HealthKeepers under contract (CS 2966) between HealthKeepers and the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer service may be reached at 855-580-1200 or through our website: www.anthem.com. The address for the HealthKeepers administrative office is:

HealthKeepers
P.O. Box 27401
Richmond, VA 23279

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One or Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2022, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefits are effective January 1, 2022, and changes are summarized in Section 2. Rates are shown at the end of this brochure.

Plain Language

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

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

Stop Healthcare Fraud!

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

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

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

- Do not give your plan identification (ID) number over the phone or to people you do not know, except for your healthcare providers, authorized health benefits plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using healthcare providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Periodically review your claims history for accuracy to ensure we have not been billed for services you did not receive.
- Do not ask your doctor to make false entries on certificates, bills, or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.

- If the provider does not resolve the matter, call us at 855-580-1200 and explain the situation.
- If we do not resolve the issue:

CALL THE HEALTHCARE FRAUD HOTLINE
877-499-7295

OR go to:
www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/

The online reporting form is the desired method of reporting fraud in order to ensure accuracy and a quicker response time.

You can also write to:

United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise)
  - Your child age 26 or over (unless they are disabled and incapable of self-support prior to age 26).

A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage (TCC).
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Discrimination is Against the Law

HealthKeepers complies with all applicable Federal civil rights laws, to include both Title VII of the Civil Rights Act of 1964 and Section 1557 of the Affordable Care Act. Pursuant to Section 1557, HealthKeepers does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, or sex.

You may file a 1557 complaint with the HHS Office of Civil Rights, an FEHB Program carrier, or OPM. You may file a civil rights complaint with OPM by mail at:

Office of Personnel Management
Healthcare and Insurance Federal Employee Insurance Operations
Attention: Assistant Director
1900 E Street NW Suite 3400-S
Washington, D.C. 20415-3610
202-606-3818 between 8 a.m. and 5 p.m. Eastern time

Curious to know what all this says? We would be too. Here's the English version: You have the right to get this information and help in your language for free. Call the Member Services number on your identification card for help. (TTY/TDD: 711)

For the translation of this statement in: Spanish, Chinese, Vietnamese, Korean, Tagalog, Russian, Arabic, Armenian, Farsi, French, Japanese, Haitian, Italian, Polish, Punjabi, and Navajo please visit our website at www.anthem.com.

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your identification card.

It's important we treat you fairly
That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your identification card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 800-368-1019, TDD: 800-537-7697 or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own healthcare and that of your family members by learning more about and understanding your risks.

Take these simple steps:

1. **Ask questions if you have doubts or concerns.**
   - Ask questions and make sure you understand the answers.
   - Choose a doctor with whom you feel comfortable talking.
   - Take a relative or friend with you to help you take notes, ask questions and understand answers.

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

- Bring the actual medication or give your doctor and pharmacist a list of all the medications and dosage that you take, including non-prescription (over-the-counter) medications and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food and other allergies you have, such as to latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medication is what the doctor ordered. Ask the pharmacist about the medication if it looks different than you expected.
- Read the label and patient package insert when you get your medication, including all warnings and instructions.
- Know how to use your medication. Especially note the times and conditions when your medication should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.
- Understand both the generic and brand names of your medication. This helps ensure you do not receive double dosing from taking both a generic and a brand. It also helps prevent you from taking a medication to which you are allergic.

3. **Get the results of any test or procedure.**
   - Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, through the Plan or Provider's portal?
   - Don't assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.
   - Ask what the results mean for your care.

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

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

Patient Safety Links

For more information on patient safety, please visit:

- www.jointcommission.org/speakup.aspx. The Joint Commission's Speak Up™ patient safety program.
- www.jointcommission.org/topics/patient_safety.aspx. The Joint Commission helps healthcare organizations to improve the quality and safety of the care they deliver.
- www.ahrq.gov/patients-consumers. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality healthcare providers and improve the quality of care you receive.
- www.bemedwise.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medications.

- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and healthcare professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions ("Never Events")

When you enter the hospital for treatment of one medical problem, you do not expect to leave with additional injuries, infections, or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, can indicate a significant problem in the safety and credibility of a healthcare facility. These conditions and errors are sometimes called "Never Events" or "Serious Reportable Events."

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores, and fractures, and to reduce medical errors that should never happen. When such an event occurs, neither you nor your FEHB plan will incur costs to correct the medical error. Should an event occur and you were required to make payments to the provider you will be reimbursed for your out-of-pocket costs. The list of Never Events or Hospital Acquired Conditions is as follows:

- Surgery performed on the wrong body part
- Surgery performed on the wrong patient
- Wrong surgical procedure performed on a patient
- Unintended retention of a foreign object in a patient after surgery or other procedure
- Air embolism
- Blood Incompatibility
- Surgical site infection following bariatric surgery for obesity (laparoscopic gastric bypass, gastroenterostomy, laparoscopic gastric restrictive surgery)
- Surgical site infection, mediastinitis, following coronary artery bypass graft
- Surgical site infection following certain orthopedic procedures (spine, neck, shoulder, elbow)
- Deep vein thrombosis and pulmonary embolism following certain orthopedic procedures (total knee replacement, hip replacement)
- Catheter associated urinary tract infection
- Manifestations of poor glycemic control (diabetic ketoacidosis, nonketotic hyperosmolar coma, hypoglycemic coma, secondary diabetes with ketoacidosis, secondary diabetes with hyperosmolarity)
- Vascular catheter associated infection
- Falls and trauma (fracture, dislocation, intracranial injury, crushing injury, burn, electric shock)
- Pressure ulcers, stages III and IV

FEHB Facts

Coverage information

- **No pre-existing condition limitation**

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

- **Minimum essential coverage (MEC)**

  Coverage under this plan qualifies as minimum essential coverage. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard (MVS)**

  Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.

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

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

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

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

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

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

  Once enrolled in your FEHB Program Plan, you should contact your carrier directly for address updates and questions about your benefit coverage.

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

  Self Only coverage is only for the enrollee. Self Plus One coverage is for the enrollee and one eligible family member. Self and Family coverage is for the enrollee and one or more eligible family members. Family members include your spouse and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self Plus One or Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self Plus One or Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self Plus One or Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form. Benefits will not be available to your spouse until you are married. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

Contact your carrier to obtain a Certificate of Creditable Coverage (COCC) or to add a dependent when there is already family Coverage.

Contact your employing or retirement office if you are changing from Self to Self Plus One or Self and Family or to add a newborn if you currently have a Self Only plan.

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

If you or one of your family members is enrolled in one FEHB plan, you or they cannot be enrolled in or covered as a family member by another enrollee in another FEHB plan.

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

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including your spouse by a valid common-law marriage from a state that recognizes common-law marriages) and children as described in the chart below. A Self Plus One enrollment covers you and your spouse, or one other eligible family member as described below.

Natural children, adopted children, and stepchildren
Coverage: Natural children, adopted children, and stepchildren are covered until their 26th birthday.

Foster children
Coverage: Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.

Children incapable of self-support
Coverage: Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.

Married children
Coverage: Married children (but NOT their spouse or their own children) are covered until their 26th birthday.

Children with or eligible for employer-provided health insurance
Coverage: Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

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

- **Children's Equity Act**

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

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

- If you have no FEHB coverage, your employing office will enroll you for Self Plus One or Self and Family coverage, as appropriate, in the lowest-cost nationwide plan option as determined by OPM.
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self Plus One or Self and Family coverage, as appropriate, in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the lowest-cost nationwide plan option as determined by OPM.

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

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

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be processed according to the 2022 benefits of your prior plan or option.** If you have met (or pay cost-sharing that results in your meeting) the out-of-pocket maximum under the prior plan or option, you will not pay cost-sharing for services covered between January 1 and the effective date of coverage under your new plan or option. However, if your prior plan left the FEHB Program at the end of the year, you are covered under that plan's 2021 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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

- **When you retire**

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

You may be eligible for spouse equity coverage or assistance enrolling in a conversion policy (a non-FEHB individual policy).

- **Upon divorce**

If you are divorced from a Federal employee, or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get additional information about your coverage choices. You can also visit OPM's website: www.opm.gov/healthcare-insurance/healthcare/plan-information/. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

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

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

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

Enrolling in TCC. Get the RI 79-27, which describes TCC, from your employing or retirement office or from www.opm.gov/healthcare-insurance. It explains what you have to do to enroll.

Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a new kind of tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHB Program coverage.

- **Converting to individual coverage**

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

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

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

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, waiting period will not be imposed, and your coverage will not be limited due to pre-existing conditions. When you contact us we will assist you in obtaining information about health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace in your state. For assistance in finding coverage, please contact us at 855-580-1200 or visit our website at www.anthem.com.

- **Health Insurance Marketplace**

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

Section 1. How This Plan Works

This Plan is a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA) component. HDHPs have higher annual deductibles than other types of FEHB plans. FEHB Program HDHP's also offer Health Savings Accounts or Health Reimbursement Arrangements. Please see below for more information about these features.

OPM requires that FEHB plans be accredited to validate that plan operations and/or care management meet nationally recognized standards. HealthKeepers holds the following accreditations: National Committee for Quality Assurance and the National Committee for Quality Assurance UM Accreditation. To learn more about this plan's accreditation(s), please visit the following website:

- National Committee for Quality Assurance (www.ncqa.org)

We have Network Providers

Our network providers offer services through our Plan. When you use our network providers, you will receive covered services at reduced costs. Network benefits apply only when you use a network provider. HealthKeepers is solely responsible for the selection of network providers in your area. You can access network providers online by visiting our website at www.anthem.com, or contact us for a directory or the names of network providers by calling 855-580-1200.

Out-of-network benefits apply when you use a non-network provider.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your cost-sharing (copayments, coinsurance, deductibles, and non-covered services and supplies).

General features of our High Deductible Health Plan (HDHP)

HDHPs have higher annual deductibles and annual out-of-pocket maximum limits than other types of FEHB plans. FEHB Program HDHPs also offer health savings accounts or health reimbursement arrangements. Please see below for more information about these savings features.

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

Annual deductible
The annual deductible must be met before Plan benefits are paid for care other than preventive care services. The deductible for Network is $1,500 for Self Only, $3,000 for Self Plus One, and $3,000 for Self and Family. The deductible for Out-of-Network is $2,500 for Self Only, $5,000 for Self Plus One, and $5,000 for Self and Family.

Health Savings Account (HSA)

You are eligible for an HSA if you are enrolled in an HDHP, not covered by any other health plan that is not an HDHP (including a spouse's health plan, excluding specific injury insurance and accident, disability, dental care, vision care, or long-term coverage), not enrolled in Medicare, not received VA (except for veterans with a service-connected disability) or Indian Health Service (IHS) benefits within the last three months, not covered by your own or your spouse's flexible spending account (FSA), and are not claimed as a dependent on someone else's tax return.

- You may use the money in your HSA to pay all or a portion of the annual deductible, copayments, coinsurance, or other out-of-pocket costs that meet the IRS definition of a qualified medical expense.
- Distributions from your HSA are tax-free for qualified medical expenses for you, your spouse, and your dependents, even if they are not covered by a HDHP.

- You may withdraw money from your HSA for items other than qualified medical expenses, but it will be subject to income tax and, if you are under 65 years old, an additional 20% penalty tax on the amount withdrawn.
- For each month that you are enrolled in an HDHP and eligible for an HSA, the HDHP will pass through (contribute) a portion of the health plan premium to your HSA. In addition, you (the account holder) may contribute your own money to your HSA up to an allowable amount determined by IRS rules. Your HSA dollars earn tax-free interest.
- You may allow the contributions in your HSA to grow over time, like a savings account. The HSA is portable – you may take the HSA with you if you leave the Federal government or switch to another plan.

Health Reimbursement Arrangement (HRA)

If you are not eligible for an HSA, or become ineligible to continue an HSA, you are eligible for a Health Reimbursement Arrangement (HRA). Although an HRA is similar to an HSA, there are major differences.

- An HRA does not earn interest.
- An HRA is not portable if you leave the Federal government or switch to another plan

Catastrophic protection for your HDHP

We protect you against catastrophic out-of-pocket expenses for covered services. The IRS limits annual out-of-pocket expenses for covered services, including deductibles and copayments, to no more than $7,000 for Self Only enrollment, and $14,000 for a Self Plus One or Self and Family. The out-of-pocket limit for this Plan may differ from the IRS limit, but cannot exceed that amount. After your network deductible, copayments and coinsurance total $5,000 for Self Only or $5,000 per person for Self Plus One, or $10,000 per Self and Family enrollment in any calendar year, you do not have to pay any more for covered network services. After your out-of-network deductible, copayments and coinsurance total $7,000 for Self Only or $7,000 per person for Self Plus One, or $14,000 per Self and Family enrollment in any calendar year, you do not have to pay any more for covered out-of-network services.

Your rights and responsibilities

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

- HealthKeepers has been in existence since 1985
- HealthKeepers is a for-profit organization

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities by visiting our website, www,anthem.com. You can also contact us to request that we mail a copy to you.

If you want more information about us, call 855-580-1200 or write to HealthKeepers at P.O. Box 27401, Richmond, VA 23279. You may also visit our website at www,anthem.com.

By law, you have the right to access your protected health information (PHI). For more information regarding access to PHI, visit our website at www,anthem.com to obtain our Notice of Privacy Practices. You can also contact us to request that we mail you a copy of that Notice.

Your medical and claims records are confidential

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

HDHP Service Area

To enroll in this Plan, you must live in our service area. This is where our network providers practice. Our service area is:

The counties of – Accomack, Albemarle, Augusta, Caroline, Charles City, Chesterfield, Clarke, Culpeper, Dinwiddie, Essex, Fairfax (west of St. Rt. 123 only), Fauquier, Fluvanna, Frederick, Gloucester, Goochland, Greene, Hanover, Henrico, Isle Of Wight, James City, King And Queen, King George, King William, Lancaster, Loudon, Louisa, Madison, Mathews, Middlesex, New Kent, Northhampton, Northumberland, Orange, Page, Prince George, Prince William (west of St. Rt. 123 only), Rappahannock, Richmond County, Rockingham, Shenandoah, Southampton, Spotsylvania, Stafford, Surry, Sussex, Warren, Westmoreland, and York and;

The cities of - Charlottesville, Chesapeake, Colonial Heights, Franklin, Fredericksburg, Hampton, Hopewell, Manassas, Manassas Park, Newport News, Norfolk, Petersburg, Poquoson, Portsmouth, Richmond, Suffolk, Virginia Beach, and Williamsburg.

If you or a covered family member move or live outside of our service areas, you can continue to access out-of-network care or you can enroll in another plan. If you or a covered family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. Changes for 2022

This is a new Plan for 2022. Please familiarize yourself with the benefits and limitations of the Plan.

Section 3. How You Get Care

Identification cards

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

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

Where you get covered care

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

- **Plan providers**

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

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

This plan recognizes that transsexual, transgender, and gender-nonconforming members require healthcare delivered by healthcare providers experienced in transgender health. While gender reassignment surgeons (benefit details found in Section 5(b)) and hormone therapy providers (benefit details found in Section 5(f)) play important roles in preventive care, you should see a primary care provider familiar with your overall healthcare needs. Benefits described in this brochure are available to all members meeting medical necessity guidelines.

- **Plan facilities**

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

What you must do to get covered care

It depends on the kind of care you want to receive. You can go to any provider you want, but we must approve some care in advance.

- **Primary care**

Selecting a Primary Care Physician (PCP) is important. A PCP can be a family practitioner, internist, or pediatrician. Your PCP will provide most of your healthcare.

- **Specialty care**

Here are some things you should know about specialty care:

You do not need a referral from your primary care physician. You may self-refer within the network for medically necessary care.

If you have a chronic and disabling condition and lose access to your specialist because we:

- terminate our contract with your specialist for other than cause;
- drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program plan; or
- reduce our Service Area and you enroll in another FEHB plan;

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

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

Inpatient, residential treatment and certain outpatient treatment for mental health and substance use require precertification. When you remain within our network, the provider is responsible for contacting us to obtain precertification. However, when you seek non-network care under HealthKeepers, you are ultimately responsible for contacting us to obtain precertification.

- **Hospital care**

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

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

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

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

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

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

Balance Billing Protection

FEHB Carriers must have clauses in their in-network (participating) providers agreements. These clauses provide that, for a service that is a covered benefit in the plan brochure or for services determined not medically necessary, the network provider agrees to hold the covered individual harmless (and may not bill) for the difference between the billed charge and the network contracted amount. If a network provider bills you for covered services over your normal cost share (deductible, copay, co-insurance) contact your Carrier to enforce the terms of its provider contract.

You need prior Plan approval for certain services

If you choose an out-of-network provider, be sure to call us to see if you need pre-authorization. Providers who are not in the network may not do that for you. If you ever have a question about whether you need pre-authorization, just call the pre-authorization or precertification phone number on your member identification card.

- **Inpatient hospital admission**

Precertification is the process by which – prior to your inpatient hospital admission – we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition.

- **Other services**

Your network primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain prior approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice. If you seek covered care from non-network providers you are ultimately responsible for contacting us to obtain our prior approval before proceeding with the service(s). We call this review and approval process precertification. The following list includes, but is not limited to, services that require precertification:

- All inpatient admissions (except maternity)
- Newborn stays beyond the discharge of the mother
- Transplants (Human Organ and Bone Marrow/Stem Cell)
- Lumbar spinal fusion surgeries
- Uvulopalatopharyngoplasty, uvulopharyngoplasty surgery (UPPP)
- Plastic/Reconstructive surgeries such as but not limited to: Blepharoplasty, Rhinoplasty, and Panniculectomy and Lipectomy/diatasis Recti Repair
- Durable Medical Equipment (DME) – specialized or motorized/powered wheelchairs and accessories, hospital beds, rocking beds and air beds
- Prosthetics – electronically or externally powered and custom made and/or custom fitted prefabricated orthotics and braces
- Surgical treatment of morbid obesity
- Private duty nursing in a home setting
- Certain prescription drugs, such as Growth Hormones
- Diagnostic imaging such as, but not limited to: Computed Tomography (CT), Computed Tomographic Angiography (CTA), Magnetic Resonance Angiography (MRA), Magnetic Resonance Imaging (MRI), Magnetic Resonance Spectroscopy (MRS), Nuclear Cardiology and Positron Emission Tomography (PET)
- Mental health/Substance use services such as but not limited to: Inpatient admissions, intensive outpatient therapy, partial hospitalization, residential care and Electric Convulsive Therapy (ECT)
- Gender Reassignment services
- Genetic testing
- Office and outpatient physical, occupational and speech therapy
- Applied Behavior Analysis (ABA) services

Precertification is a feature that requires an approval be obtained from us before incurring expenses for certain covered services. When care is evaluated, both medical necessity and appropriate length of stay will be determined. Medical necessity includes a review of both the services and the setting. For certain services you will be required to use the provider designated by Our Healthcare Management staff. The care will be covered according to your benefits for the number of days approved unless our concurrent review determines that the number of days should be revised. If a request is denied, the provider may request a reconsideration. An expedited reconsideration may be requested when your health requires an earlier decision.

For emergency admissions, precertification is not required. However, you must notify us of your admission within 24 hours or as soon as possible within a reasonable period of time.

Predetermination is the process of requesting approval of benefits before the service or supply is rendered.

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

First, your physician, your hospital, you, or your representative, must call us at 800-676-2583 before admission or services requiring prior authorization are rendered.

Next, provide the following information:

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

- name of hospital or facility; and
- number of days requested for hospital stay.

- **Non-urgent care claims**

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

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

- **Urgent care claims**

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

If you fail to provide sufficient information, we will contact you verbally within 24 hours after we receive the claim to let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide the required information. We will make our decision on the claim within 48 hours (1) of the time we received the additional information or (2) the end of the time frame, whichever is earlier.

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

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

- **Concurrent care claims**

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

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

- **Emergency inpatient admission**

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

- **Maternity care**

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

  Note: When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.

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

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

- **What happens when you do not follow the precertification rules when using non-network facilities**

  Since precertification is part of the prior approval process you would need approval to use a non-network facility. If you use a non-network facility without prior approval or precertification you may be financially responsible for the charges. You should always make sure that we have been contacted to perform precertification for non-network services.

Circumstances beyond our control

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

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below.

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

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

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

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

  1. Precertify your hospital stay or, if applicable, arrange for the healthcare provider to give you the care or grant your request for prior approval for a service, drug, or supply; or
  2. Ask you or your provider for more information.
     - You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.
     - If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
  3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

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

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

- **To file an appeal with OPM**

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

The Federal Flexible Spending Account Program – *FSAFEDS*

- **Healthcare FSA (HCFSA)** – Reimburses you for eligible out-of-pocket healthcare expenses (such as copayments, deductibles, **physician prescribed** over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26).
- FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.

Section 4. Your Cost for Covered Services

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

Cost-sharing

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

Copayments

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

Example: Once you meet your deductible you will pay a copayment of $10 for each Tier 1 prescription drug.

Deductible

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

In network
Under a Self Only enrollment, the deductible is considered satisfied and benefits are payable for you when your covered network expenses applied to the calendar year deductible for your enrollment reach $1,500. Under a Self Plus One enrollment, the deductible is considered satisfied and benefits are payable for you and one other eligible family member when the combined covered expenses applied to the calendar year deductible for your enrollment reach $3,000. Under a Self and Family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $3,000.

Out of network
Under a Self Only enrollment, the deductible is considered satisfied and benefits are payable for you when your covered out of network expenses applied to the calendar year deductible for your enrollment reach $2,500. Under a Self Plus One enrollment, the deductible is considered satisfied and benefits are payable for you and one other eligible family member when the combined covered expenses applied to the calendar year deductible for your enrollment reach $5,000. Under a Self and Family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $5,000.

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

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

Coinsurance

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

Example: In our Plan, you pay 20% of our allowance for network and 40% of our allowance for non-network durable medical equipment.

Differences between our Plan allowance and the bill

When you receive covered services from non-network providers you are responsible for the difference between the actual charge and the Plan's maximum allowable amount.

You should also see section Important Notice About Surprise Billing – Know Your Rights below that describes your protections against surprise billing under the No Surprises Act.

Your catastrophic protection out-of-pocket maximum

In network
After your deductible, copayments and coinsurance total $5,000 for Self Only enrollment, or $10,000 per Self Plus One enrollment, or $10,000 per Self and Family enrollment in any calendar year, you do not have to pay any more for covered network services.

Out of network
After your deductible, copayments and coinsurance total $7,000 for Self Only enrollment, or $14,000 per Self Plus One enrollment, or $14,000 per Self and Family enrollment in any calendar year, you do not have to pay any more for covered out of network services.

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

Carryover

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

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

When Government facilities bill us

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

Important Notice About Surprise Billing - Know Your Rights

The No Surprises Act (NSA) is a federal law that provides you with protections against "surprise billing" and "balance billing" under certain circumstances. A surprise bill is an unexpected bill you receive from a nonparticipating health care provider, facility, or air ambulance service for healthcare. Surprise bills can happen when you receive emergency care – when you have little or no say in the facility or provider from whom you receive care. They can also happen when you receive non-emergency services at participating facilities, but you receive some care from nonparticipating providers.

Balance billing happens when you receive a bill from the nonparticipating provider, facility, or air ambulance service for the difference between the nonparticipating provider's charge and the amount payable by your health plan.

Your health plan must comply with the NSA protections that hold you harmless from unexpected bills.

In addition, your health plan adopts and complies with the surprise billing laws of Virginia**.**

For specific information on surprise billing, the rights and protections you have, and your responsibilities go to www.anthem.com or contact the health plan at 855-580-1200.

Section5. High Deductible Health Plan Benefits

See Section 2 for how our benefits changed this year and Summary of Benefits for a benefits summary.

Section 5. High Deductible Health Plan Benefits Overview

This Plan offers a High Deductible Health Plan (HDHP). The HDHP benefit package is described in this Section. Make sure that you review the benefits carefully.

HDHP Section 5, which describes the HDHP benefits, is divided into subsections. Please read Important things you should keep in mind about these benefits at the beginning of each subsection. Also read the general exclusions in Section 6; they apply to benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about HDHP benefits, contact us at 855-580-1200 or on our website at www.Anthem.com.

Our HDHP option provides comprehensive coverage for high-cost medical events and a tax-advantaged way to help you build savings for future medical expenses. The Plan gives you greater control over how you use your healthcare benefits.

When you enroll in this HDHP, we establish either a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA) for you. We automatically pass through a portion of the total health Plan premium to your HSA or credit an equal amount to your HRA based upon your eligibility. Your full annual HRA credit will be available on your effective date of enrollment.

With this Plan, preventive care is covered in full. As you receive other non-preventive medical care, you must meet the Plan's deductible before we pay benefits according to the benefits described in Section 5. *Preventive Care*. You can choose to use funds available in your HSA to make payments toward the deductible or you can pay toward your deductible entirely out-of-pocket, allowing your savings to continue to grow.

This HDHP includes five key components: preventive care; traditional medical coverage healthcare that is subject to the deductible; savings; catastrophic protection for out-of-pocket expenses; and health education resources and account management tools.

- **Preventive Care** — The Plan covers preventive care services, such as periodic health evaluations (e.g., annual physicals), screening services (e.g., mammograms), routine prenatal and well-child care, child and adult immunizations, tobacco cessation programs, obesity weight loss programs, disease management and wellness programs. These services are covered at 100% if you use a network provider and the services are described in Section 5 Preventive care. You do not have to meet the deductible before using these services.

- **Traditional medical coverage** — After you have paid the Plan's deductible, we pay benefits under traditional medical coverage described in Section 5. The Plan typically pays 80% for network and 60% for out-of-network care.

  Covered services include:

  - Medical services and supplies provided by physicians and other healthcare professionals
  - Surgical and anesthesia services provided by physicians and other healthcare professionals
  - Hospital services; other facility or ambulance services
  - Emergency services/accidents
  - Mental health and substance use benefits
  - Prescription drug benefits

- **Savings** — Health Savings Accounts or Health Reimbursement Arrangements provide a means to help you pay out-of-pocket expenses.

Health Savings Accounts (HSAs)

By law, HSAs are available to members who are not enrolled in Medicare, cannot be claimed as a dependent on someone else's tax return, have not received VA (except for veterans with a service-connected disability) and/or Indian Health Services (IHS) benefits within the last three months or do not have other health insurance coverage other than another High Deductible Health Plan. In 2022, for each month you are eligible for an HSA premium pass through, we will contribute to your HSA $75 per month for a Self Only enrollment or $150 per month for a Self Plus One enrollment or $150 per month for a Self and Family enrollment. In addition to our monthly contribution, you have the option to make additional tax-free contributions to your HSA, so long as total contributions do not exceed the limit established by law, which is for 2022, $3,650 for an individual and $7,300 for a family. See maximum contribution information in Section 5. *Savings -- HSAs and HRAs*. You can use funds in your HSA to help pay your health plan deductible**.** You own your HSA, so the funds can go with you if you change plans or employment.

Federal tax tip: There are tax advantages to fully funding your HSA as quickly as possible. Your HSA contribution payments are fully deductible on your Federal tax return. By fully funding your HSA early in the year, you have the flexibility of paying medical expenses from tax-free HSA dollars or after tax out-of-pocket dollars. If you don't deplete your HSA and you allow the contributions and the tax-free interest to accumulate, your HSA grows more quickly for future expenses.

HSA features include:

- Administration – Your HSA is administered by Anthem Insurance Companies, Inc.
- Lower monthly payments – the Anthem HSA plans cost less per paycheck, though you will have a higher deductible. The deductible is the amount you pay out of pocket for medical expenses before the plan begins to pay.
- Paying expenses – Your plan will come with an Anthem-branded MasterCard Debit Card. You can also make online payments to your provider and pharmacy or even reimburse using the Sydney Health mobile app or anthem.com
- Triple tax benefits – The money you put into an HSA is tax-free. The money you take out for qualified healthcare expenses is tax-free (see IRS publication 502 for a complete list of eligible expenses). The savings, interest, and investment growth are also tax-free.
- Long-term savings – Your deposits earn interest and continue to grow over time. Additionally, if your balance is more than $1,000, you can invest the amount over $1,000 to grow even more savings for future healthcare costs.
- Full control – When you need it, funds up to the actual HSA balance are available. You decide how you spend your HSA money. Use the money to help pay your deductible or leave it in your account and allow it to grow.
- Funds roll over – Any funds you don't use roll over to the next year. There's no "use-it-or lose-it" rule.
- The money is always yours – the HSA is yours to keep, even if you switch to a new health plan, change jobs, or retire.
- Paying expenses – Your plan will come with an Anthem-branded MasterCard Debit Card. You can also make online payments to your provider and pharmacy or even reimburse using the Sydney Health mobile app or anthem.com.

Important consideration if you want to participate in a Healthcare Flexible Spending Account (HCFSA): If you are enrolled in this HDHP with a Health Savings Account (HSA), and start or become covered by a HCFSA healthcare flexible spending account (such as FSAFEDS offers – see Section 11), this HDHP cannot continue to contribute to your HSA. Similarly, you cannot contribute to an HSA if your spouse enrolls in an HCFSA. Instead, when you inform us of your coverage in an HCFSA, we will establish an HRA for you.

Health Reimbursement Arrangements (HRA)

If you are not eligible for an HSA, for example, you are enrolled in Medicare or have another health plan, we will administer and provide an HRA instead. You must notify us that you are ineligible for an HSA.

In 2022, we will give you an HRA credit of $900 per year for a Self Only enrollment or $1,800 per year for a Self Plus One enrollment or $1,800 per year for a Self and Family enrollment. You can use funds in your HRA to help pay your health plan deductible and/or for certain expenses that don't count toward the deductible.

HRA features include:

- For our HDHP option, the HRA is administered by Anthem Insurance Companies, Inc.
- Entire HRA credit (prorated from your effective date to the end of the plan year) is available from your effective date of enrollment.
- Tax-free credit can be used to pay for qualified medical expenses for you and any individuals covered by this HDHP.
- Unused credits carryover from year to year.
- HRA credit does not earn interest.
- HRA credit is forfeited if you leave Federal employment or switch health insurance plans.
- An HRA does not affect your ability to participate in an FSAFEDS Healthcare Flexible Spending Account (HCFSA). However, you must meet FSAFEDS eligibility requirements.

- **Catastrophic protection for out-of-pocket expenses**

When you use network providers, your annual maximum for out-of-pocket expenses (deductibles, coinsurance and copayments) for covered services is limited to $5,000 for Self Only, or $5,000 per person for Self Plus One enrollment or, $10,000 for Self and Family enrollment. When you use out-of-network providers, your annual maximum for out-of-pocket expenses (deductibles, coinsurance and copayments) for covered services is limited to $7,000 for Self Only, or $7,000 per person for Self Plus One enrollment or, $14,000 for Self and Family enrollment. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's allowable amount or benefit maximum). Refer to Section 4 Your catastrophic protection out-of-pocket maximum and HDHP Section 5 *Traditional medical coverage subject to the deductible* for more details.

Section 5. Savings – HSAs and HRAs

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) Provided when you are ineligible for an HSA
Administrator	The Plan will establish an HSA for you with Anthem Insurance Companies, Inc. and WealthCare Saver, this HDHP's fiduciary (an administrator, trustee or custodian as defined by Federal tax code and approved by IRS). You will be responsible for opening the bank account. The Plan does not open the account for you.	Anthem Insurance Companies, Inc. is the HRA fiduciary for this Plan.
Fees	There is no HSA set-up fee. The following is a list of standard administrative and other related fees that may be charged to your HSA account by your Administrator. • Monthly administrative fee $2.25 • Closure fee $25.00 per occurrence • Paper Statement fee $1.50 per quarter • Monthly Investment fee $2.25	None
Eligibility	You must: • Enroll in the Anthem Insurance Companies, Inc. High Deductible Health Plan (HDHP) • Have no other health insurance coverage (does not apply to another HDHP, specific injury, accident, disability, dental, vision or long-term care coverage) • Not be enrolled in Medicare • Not be claimed as a dependent on someone else's tax return • Not currently receiving VA benefits or services (except for veterans with a service-connected disability) and/or Indian Health Service (IHS) benefits in the last three months • Complete and return all supplemental banking paperwork required to open your HSA with WealthCare Saver.	You must enroll in the Anthem Insurance Companies, Inc. High Deductible Health Plan (HDHP). If you enroll in an HDHP during open season or in the month of January, your HRA will be funded up to the yearly maximum. If you enroll outside of open season or other than the month of January, the funding of your HRA will be prorated based on each full month in which you are enrolled in an HDHP. Eligibility is determined on the day of enrollment and will be prorated monthly for length of enrollment.

Funding	If you are eligible for HSA contributions, a portion of your monthly health plan premium is deposited to your HSA each month when the premium is received. Premium pass through contributions are based on the effective date of your enrollment in the Anthem Insurance Companies, Inc. High Deductible Health Plan (HDHP). Note: If your effective date in the HDHP is after the 1st of the month, the earliest your HSA will be established is the 1st of the following month. In addition, you may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions. You may contribute to your HSA outside of payroll deductions by submitting a contribution coupon or setting up an electronic funds transfer from your checking or savings account, up to the annual maximum contribution. You can obtain additional HSA forms by logging into www.anthem.com. Contribution forms and electronic funds transfer are available at www.anthem.com.	Eligibility for the annual credit will be determined on the first day of the month and will be prorated for length of enrollment. The entire amount of your HRA will be available to you upon your enrollment.
• **Self Only enrollment**	For 2022, a monthly premium pass through of $75 will be made by the HDHP directly into your HSA each month upon receipt of premium.	For 2022, your HRA annual credit is $900 (prorated for mid-year enrollment).
• **Self Plus One enrollment**	For 2022, a monthly premium pass through of $150 will be made by the HDHP directly into your HSA each month upon receipt of premium.	For 2022, your HRA annual credit is $1,800 (prorated for mid-year enrollment).
• **Self and Family enrollment**	For 2022, a monthly premium pass through of $150 will be made by the HDHP directly into your HSA each month upon receipt of premium.	For 2022, your HRA annual credit is $1,800 (prorated for mid-year enrollment).
Contributions/ credits	The maximum that can be contributed to your HSA is an annual combination of HDHP premium pass through and enrollee contribution funds, which when combined, do not exceed the maximum contribution amount set by the IRS of $3,650 for an individual and $7,300 for a family.	The full HRA credit will be available, subject to proration, on the effective date of enrollment. The HRA does not earn interest. You cannot contribute to an HRA.

	If you enroll during Open Season, you are eligible to fund your account up to the maximum contribution limit set by the IRS. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum allowable contribution. NOTE: Annual premium pass through contributions will be forfeited if you do not open an HSA by 12/31 of that plan year. You are eligible to contribute up to the IRS limit for partial year coverage as long as you maintain your HDHP enrollment for 12 months following the last month of the year of your first year of eligibility. To determine the amount you may contribute, take the IRS limit and subtract the amount the Plan will contribute to your account for the year. If you do not meet the 12 month requirement, the maximum contribution amount is reduced by 1/12 for any month you were ineligible to contribute to an HSA. If you exceed the maximum contribution amount, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death or disability. You may rollover funds you have in other HSAs to this HDHP HSA (rollover funds do not affect your annual maximum contribution under this HDHP). HSAs earn tax-free interest (does not affect your annual maximum contribution). If you are age 55 or older, the IRS permits you to make additional "catch-up" contributions to your HSA. The allowable catch-up contribution is $1,000. Contributions must stop once an individual is enrolled in Medicare.	
• **Self Only enrollment**	You may make an additional voluntary contribution. Your contributions and the pass through premiums are limited to $3,650 for 2022.	You cannot contribute to the HRA.
• **Self Plus One enrollment**	You may make an additional voluntary contribution. Your contributions and the pass through premiums are limited to $7,300 for 2022.	You cannot contribute to the HRA.
• **Self and Family enrollment**	You may make an additional voluntary contribution. Your contributions and the pass through premiums are limited to $7,300 for 2022.	You cannot contribute to the HRA.

Access funds	You can access your HSA by the following methods: • You can access your new HSA to make online payments to your provider and pharmacy or even reimburse yourself using the Sydney Health mobile app that you can download at Google Play™ or the App Store® or at anthem.com. • Your new Anthem-branded Health Savings Account MasterCard Debit Card is connected to this account. When it arrives in the mail, call the number on the card to activate it. • You'll get a **welcome** communication from WealthCare Saver in the mail with important details about your account.	For qualified medical expenses under your Anthem Insurance Companies, Inc. HDHP, you will be automatically reimbursed, if there are available funds in your HRA, when claims are submitted through the Anthem Insurance Companies, Inc. High Deductible Health Plan.
Distributions/withdrawals • **Medical**	You can pay the out-of-pocket expenses for yourself, your spouse or your dependents (even if they are not covered by the HDHP) from the funds available in your HSA. You may use the Anthem-branded Health Savings Account Mastercard Debit Card for all qualified expenses. The Debit Card must be activated in order to have access to HSA funds, customer service and online information. You can also make online payments to your provider and pharmacy or even reimburse yourself using the Sydney Health mobile app or anthem.com. Visit www.anthem.com for a list of qualified medical expenses.	You can pay the out-of-pocket expenses for qualified medical expenses for individuals covered under the Anthem Insurance Companies, Inc. HDHP. See *Availability of funds* below for information on when funds are available in the HRA. Visit www.anthem.com for a list of qualified medical expenses.
• **Non-medical**	If you are under age 65, withdrawal of funds for non-qualified expenses will create a 20% income tax penalty in addition to any other income taxes you may owe on the withdrawn funds. When you turn age 65, distributions can be used for any reason without being subject to the 20% penalty, however they will be subject to ordinary income tax.	Not applicable – distributions will not be made for anything other than non-reimbursed qualified medical and Rx expenses.
Availability of funds	Funds are not available for withdrawal until all the following steps are completed: • Your enrollment in this HDHP is effective (effective date is determined by your agency in accord with the event permitting the enrollment change). • Any additional information required to open your HSA is provided.	Funds are not available for withdrawal until: • Your enrollment in this HDHP is effective (effective date is determined by your agency in accord with the event permitting the enrollment change).

	• NOTE: Annual premium pass through contributions will be forfeited if you do not open your HSA by December 31 of the current plan year.	• The entire amount of your HRA will be available to you upon your enrollment in the HDHP, and verification received by the plan that you are not eligible for a Health Savings Account. (The amount of your HRA will be prorated based on the effective date of coverage.)
Account owner	FEHB enrollee	Anthem Insurance Companies, Inc. High Deductible Health Plan
Portable	You can take this account with you when you change plans, separate or retire. If you do not enroll in another HDHP, you can no longer contribute to your HSA.	If you retire and remain in this HDHP, you may continue to use and accumulate credits in your HRA. If you terminate employment or change health plans, only eligible expenses incurred while covered under the HDHP will be eligible for reimbursement subject to timely filing requirements. Unused funds are forfeited.
Annual rollover	Yes, accumulates without a maximum cap.	Yes, accumulates without a maximum cap.

If you have an HSA

- **Contributions**

  All contributions are aggregated and cannot exceed the maximum contribution amount set by the IRS. You may contribute your own money to your account through payroll deductions, or you may make lump sum contributions at any time, in any amount not to exceed an annual maximum limit. If you contribute, you can claim the total amount you contributed for the year as a tax deduction when you file your income taxes. Your own HSA contributions are either tax-deductible or pre-tax (if made by payroll deduction). You receive tax advantages in any case. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum contribution amount set by the IRS. You have until April 15 of the following year to make HSA contributions for the current year.

  If you newly enroll in an HDHP during Open Season and your effective data is after January 1st or you otherwise have partial year coverage, you are eligible to fund your account up to the maximum contribution limit set by the IRS as long as you maintain your HDHP enrollment for 12 months following the last month of the year of your first year of eligibility. If you do not meet this requirement, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death or disability.

- **Catch-up contributions**

  If you are age 55 or older, the IRS permits you to make additional "catch-up" contributions to your HSA. The allowable catch-up contribution is $1,000. Contributions must stop once an individual is enrolled in Medicare. Additional details are available on the U.S. Department of Treasury website at www.treasury.gov/resource-center/faqs/Taxes/Pages/Health-Savings-Accounts.aspx.

- **If you die**

  If you have not named a beneficiary and you are married, your HSA becomes your spouse's; otherwise, your HSA becomes part of your taxable estate.

- **Investment Options**

  Participation in voluntary investment options is entirely optional.

  Key things you need to know as you begin:

  - Minimum Balance is Required: With an HSA account balance over $1,000, you can establish an investment account. Any funds above this threshold can be invested in this account.
  - Investments Are Self-Directed: You control which funds you invest in.
  - Online Account Management: You can manage your investments online via your HSA account.

- **Qualified expenses**

  You can pay for "qualified medical expenses," as defined by IRS Code 213(d). These expenses include, but are not limited to, medical plan deductibles, diagnostic services covered by your plan, long-term care premiums, health insurance premiums if you are receiving Federal unemployment compensation, LASIK surgery, and some nursing services.

  When you enroll in Medicare, you can use the account to pay Medicare premiums or to purchase health insurance other than a Medigap policy. You may not, however, continue to make contributions to your HSA once you are enrolled in Medicare.

  For a detailed list of IRS-allowable expenses, request a copy of IRS Publication 502 by calling 1-800-829-3676, or visit the IRS website at www.irs.gov and click on "Forms and Publications." Note: Although **physician prescribed** over-the-counter drugs are not listed in the publication, they are reimbursable from your HSA. Also, insurance premiums are reimbursable under limited circumstances.

- **Non-qualified expenses**

  You may withdraw money from your HSA for items other than qualified health expenses, but it will be subject to income tax and if you are under 65 years old, an additional 20% penalty tax on the amount withdrawn.

- **Tracking your HSA balance** — You will receive a quarterly statement from WealthCare Saver. This statement shows the "premium pass through" deposits, withdrawals, and interest earned on your account. In addition, you will receive an Explanation of Payment statement when you withdraw money from your HSA.
- **Minimum reimbursements from your HSA** — You may make payments to providers or reimbursements to yourself in any amount via your Anthem Health Savings Account MasterCard Debit Card or online bill pay.

If you have an HRA

- **Why an HRA is established** — If you don't qualify for an HSA when you enroll in this HDHP, or later become ineligible for an HSA, we will establish an HRA for you. If you are enrolled in Medicare, you are ineligible for an HSA and we will establish an HRA for you. You must tell us if you are or become ineligible to contribute to an HSA.
- **How an HRA differs** — Please review the chart in Section 5. Savings – HSAs and HRAs which details the differences between an HRA and HSA. The major differences are:
  - you cannot make contributions to an HRA
  - funds are forfeited if you leave the HDHP
  - an HRA does not earn interest
  - HRAs can only pay for qualified medical expenses, such as deductibles, copayments, and coinsurance expenses, for individuals covered by the HDHP. FEHB law does not permit qualified medical expenses to include services, drugs or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.

Section 5. Preventive Care

Important things you should keep in mind about these preventive care benefits:

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically
- Preventive care is healthcare services designed for prevention and early detection of illness in average risk, people without symptoms, generally including routine physical examinations, tests and immunizations. We follow the U.S. Preventive Services Task Force recommendations for preventive care unless noted otherwise.
- The Plan pays 100% for the medical preventive care services listed in this Section as long as you use a network
- If you choose to access preventive care from a non-network provider, you will not qualify for 100% preventive care coverage. Please see Section 5 – Traditional medical coverage subject to the deductible.
- For preventive care not listed in this Section, preventive care from a non-network provider, or any other covered expenses, please see Section 5 – Traditional medical coverage subject to the deductible.

Benefit Description	You pay
Preventive Care, adult	
• Routine physicals • Routine prenatal care • Tobacco Cessation programs The following preventive services are covered at the time interval recommended at each of the links below. • Immunizations such as Pneumococcal, influenza, shingles, tetanus/DTaP, and human papillomavirus (HPV). For a complete list of immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/ • Screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV, and colorectal cancer screening. For a complete list of screenings go to the U.S. Preventive Services Task Force (USPSTF) website at https://www.uspreventiveservicestaskforce.org • Individual counseling on prevention and reducing health risks	Network: Nothing Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount.
• Well woman care such as Pap smears, gonorrhea prophylactic medication to protect newborns, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. For a complete list of Well Women preventive care services please visit the Health and Human Services (HHS) website at https://www.healthcare.gov/preventive-care-women/	Network: Nothing Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount.

Preventive Care, adult - continued on next page

Benefit Description	You pay
Preventive Care, adult (cont.)	
• Routine mammogram	Network: Nothing Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount.
• Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC): based on the Advisory Committee on Immunization Practices (ACIP) schedule.	Network: Nothing Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount.
Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or* • *Immunizations, boosters, and medications for travel or work-related exposure*	*All charges*
Preventive Care, children	
• Well-child visits, examinations, and other preventive services as described in the Bright Future Guidelines provided by the American Academy of Pediatrics. For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to https://brightfutures.aap.org • Immunizations such as DTaP, Polio, Measles, Mumps, and Rubella (MMR), and Varicella. For a complete list of immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/index.html • You can also find a complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) online at https://www.uspreventiveservicestaskforce.org Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	Network: Nothing Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount.
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure.*	*All charges*

Section 5. Traditional Medical Coverage Subject to the Deductible

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Network preventive care is covered at 100% (see Section 5. *Preventive Care*) and is not subject to the calendar year deductible.
- The network deductible is $1,500 per Self enrollment ($3,000 per Self Plus One enrollment, or $3,000 per Self and Family enrollment). The out-of-network deductible is $2,500 per Self enrollment ($5,000 per Self Plus One enrollment, or $5,000 per Self and Family enrollment). The deductible applies to almost all benefits under Traditional medical coverage. You must pay your deductible before your Traditional medical coverage may begin.
- Under Traditional medical coverage, you are responsible for your coinsurance and copayments for covered expenses.
- Your catastrophic out-of-pocket maximum for network services is $5,000 per Self enrollment, $10,000 for Self Plus One enrollment or $10,000 for Self and Family enrollment per calendar year. The catastrophic out-of-pocket maximum for out-of-network services is $7,000 per Self enrollment, $14,000 per Self Plus One enrollment or $14,000 per Self and Family enrollment. However, certain expenses do not count toward your out-of-network pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's benefit maximum, or amounts in excess of the Plan allowance).
- Network benefits apply only when you use a network provider. When a network provider is not available, out-of-network benefits apply.
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay After the calendar year deductible...
Deductible before Traditional medical coverage begins	**HDHP**
You must satisfy your deductible before your Traditional medical coverage begins. The Self, Self Plus One and Self and Family deductible can be satisfied by one or more family members. Once your Traditional medical coverage begins, you will be responsible for your coinsurance amounts for eligible medical expenses or copayments for eligible prescriptions, until you reach the annual catastrophic protection out-of-pocket maximum. At that point, we pay eligible medical expenses for the remainder of the calendar year at 100%. Network and out-of- network deductibles do not cross apply and will need to be met separately for traditional benefits to begin.	100% of allowable charges until you meet the deductible: Network: $1,500 for Self Only enrollment, $3,000 for Self Plus One enrollment and $3,000 for Self and Family enrollment. Out-of-network: $2,500 for Self Only enrollment, $5,000 for Self Plus One enrollment and $5,000 for Self and Family enrollment.

Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The network deductible is $1,500 per Self enrollment ($3,000 per Self Plus One enrollment, or $3,000 per Self and Family enrollment). The out-of-network deductible is $2,500 per Self enrollment ($5,000 per Self Plus One enrollment, or $5,000 per Self and Family enrollment). The deductible applies to almost all benefits under Traditional medical coverage. You must pay your deductible before your Traditional medical coverage may begin. The deductible applies to all benefits in this Section unless we indicate differently.
- After you have satisfied your deductible, coverage begins for traditional medical services.
- Your catastrophic out-of-pocket maximum for network services is $5,000 per Self enrollment, $10,000 for Self Plus One enrollment or $10,000 for Self and Family enrollment per calendar year. The catastrophic out-of-pocket maximum for out-of-network services is $7,000 per Self enrollment, $14,000 per Self Plus One enrollment or $14,000 per Self and Family enrollment. However, certain expenses do not count toward your out-of-network pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's benefit maximum, or amounts in excess of the Plan allowance)
- Network benefits apply only when you use a network provider. When a network provider is not available, out-of-network benefits apply.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay After the calendar year deductible…
Diagnostic and treatment services	
Professional services of physicians • In physician's office • In an urgent care center • During a hospital stay • In a skilled nursing facility • At home • In a Retail Health clinic	Network: 20% of our allowance Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount.
Telehealth services	
Online clinic visits: • Primary care physician • Specialist • Preferred provider • Sleep medicine clinic	Network: 20% of our allowance Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount.

Benefit Description	You pay After the calendar year deductible…
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine mammograms • CT/CAT Scans, MRI, MRA, PET, nuclear cardiology imaging studies and non-maternity related ultrasounds • Ultrasound • Electrocardiogram and electroencephalogram (EEG) • Genetic testing Note: Precertification may be required see Services requiring our prior approval in Section 3.	Network: 20% of our allowance Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount.
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care – includes one routine ultrasound/sonogram for a normal pregnancy • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your vaginal delivery; see Section 3. *How You Get Care* for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. If you leave in less than 48 hours (or 96 hours after a cesarean delivery), we will cover two home visits by a registered nurse provided through a network home health agency. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. • Hospital services are covered under Section 5(c) and Surgical benefits Section 5(b). Note: When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.	Network: Nothing Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount.

Maternity care - continued on next page

Benefit Description	You pay After the calendar year deductible…
Maternity care (cont.)	
• Screening for gestational diabetes for pregnant women • Breastfeeding support, supplies and counseling for each birth	Network: Nothing Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount.
Family planning	
A range of voluntary family planning services, limited to: • Contraceptive counseling on an annual basis • Voluntary sterilization (e.g. Tubal Ligation) • Surgically implanted contraceptives • Generic injectable contraceptive drugs • Intrauterine devices (IUDs) • Diaphragms Note: We cover oral contraceptives under the prescription drug benefit.	Nothing Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount.
Not covered: • *Reversal of voluntary surgical sterilization*	*All charges*
Infertility services	
Covered Services include diagnostic tests to find the cause of infertility, such as diagnostic laparoscopy, endometrial biopsy, and semen analysis. Benefits also include services to treat the underlying medical conditions that cause infertility (e.g., endometriosis, obstructed fallopian tubes, and hormone deficiency).	Network: 20% of our allowance Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount
Not covered: • *Any assisted reproductive technology (ART) procedure or services related to such procedures, including but not limited to in-vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT), and intra-cytoplasmic sperm injection (ICSI) or artificial insemination* • *Infertility treatments rendered to dependents under the age of 18* • *Services and supplies related to the above mentioned services, including sperm processing* • *Services associated with the cryopreservation of eggs, embryos, or sperm, including collection, storage, and thawing* • *Fertility drugs* • *Any treatment not specified as covered*	*All charges*

Benefit Description	You pay After the calendar year deductible…
Allergy care	
• Testing and treatment • Allergy injections • Allergy serum	Network: 20% of our allowance Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount
Not covered: • *Provocative food testing and sublingual allergy desensitization*	*All charges*
Treatment therapies	
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/ Tissue Transplants Section 5(b). • Respiratory and inhalation therapy • Dialysis — hemodialysis and peritoneal dialysis • Intravenous (IV) Infusion Therapy in a doctor's office or facility (For IV infusion and antibiotic treatment at home, see Home Health Services.) • Applied Behavior Analysis (ABA) therapy when provided for the treatment of Autism. Note: Precertification may be required see Services requiring our prior approval in Section 3.	Network: 20% of our allowance Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount.
Physical and occupational therapies	
Up to 30 combined visits per calendar year for Rehabilitative and Habilitative Physical and Occupational therapy:	Network: 20% of our allowance Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount.
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*
Speech therapy	
• 30 visits per person, per calendar year.	Network: 20% of our allowance Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount.

Benefit Description	You pay After the calendar year deductible…
Pulmonary and cardiac rehabilitation	
• Pulmonary rehabilitation (unlimited visits) • Cardiac rehabilitation following qualifying event/condition is provided for up to 36 visits per calendar year	Network: 20% of our allowance Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount.
Hearing services (testing, treatment, and supplies)	
• Infant hearing screening • Audiological testing and medically necessary treatments for hearing problems. Note: Discounts on hearing exams, hearing services, and hearing aids are also available. Please see the Non-FEHB Benefits section of this brochure for more information.	Network: 20% of our allowance Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount
Not covered: • *Hearing aids, testing and examinations for them*	*All charges*
Vision services (testing, treatment, and supplies)	
• Treatment of eye diseases and injury	Network: 20% of our allowance Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount.
Routine eye exam • Pediatric – one exam per calendar year through a Blue View Vision provider.	Network: Nothing Out-of-network: Nothing up to the maximum allowed amount
• Adult – one exam per calendar year through a Blue View Vision provider.	Network: Nothing Out-of-network: Reimbursed up to $30
• Prescribed glasses or contact lenses when required as a result of surgery or the treatment of an accidental injury. Note: Services for exams and replacement of these eyeglasses or contact lenses will be covered only if the prescription change is related to the condition that required the original prescription.	Network: 20% of our allowance Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount.
Not covered: • *Fitting of contact lenses, except as stated above* • *Eye exercises and vision therapy* • *LASIK, radial keratotomy or keratomileusis, and excimer laser refractive keratectomy*	*All charges*

Benefit Description	You pay After the calendar year deductible…
Foot care	
• Routine foot care when you are under active treatment for a vascular disease, such as diabetes.	Network: 20% of our allowance Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount.
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet; and of any instability, imbalance or subluxation of the foot* • *Foot orthotics, orthopedic shoes or supports, unless used for a systemic illness affecting the lower limbs, such as diabetes*	*All charges*
Orthopedic and prosthetic devices	
• Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome • Breast prosthesis (whether internal or external) and surgical bras after a mastectomy • Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, defibrillator and surgically implanted breast implant following mastectomy, and lenses following cataract removal. Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) Surgical procedures. Note: Please see Section 3 for a list of services that require precertification.	Network: 20% of our allowance Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount.
• One wig, when necessitated by hair loss due to covered radiation therapy or chemotherapy	Network: 20% of our allowance Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount
Not covered: • *Orthopedic shoes (except therapeutic shoes for diabetes)* • *Heel pads and heel cups* • *Foot support devices, such as arch supports and corrective shoes unless they are an integral part of a leg brace* • *Orthotic devices used primarily for convenience, comfort or for participation in athletics*	*All charges*

Benefit Description	You pay After the calendar year deductible…
Durable medical equipment (DME)	
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include but are not limited to: • Oxygen • Dialysis equipment • Hospital beds • Wheelchairs (motorized wheelchairs and scooters must be preauthorized) • Crutches • Walkers • Medical supplies, such as surgical dressings and colostomy bags and casting supplies Note: Some DME may require precertification, See Section 3.	Network: 20% of our allowance Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount
Not covered: • *Devices and equipment used for environmental control or to enhance the environmental setting, such as air conditioners, humidifiers or air filters* • *Personal hygiene and convenience items*	*All charges*
Home health services	
We cover home healthcare furnished by a home health agency or provider. Covered Services include but are not limited to: • Intermittent Skilled Nursing Services (by an R.N. or L.P.N.) • Medical/Social Services • Diagnostic Services • Nutritional Guidance • Home Health Aide Services • Therapy Services (except for Manipulation Therapy which will not be covered when rendered in the home) • Medical/Surgical Supplies • Durable Medical Equipment • Private duty nursing Note: In-home intensive behavioral health visits are covered if available in your area. See Section 5(e).	Network: 20% of our allowance Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount
Intravenous (IV) Infusion Therapy and medications	Network: 20% of our allowance Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount.

Home health services - continued on next page

Benefit Description	You pay After the calendar year deductible…
Home health services (cont.)	
Not covered: • *Custodial care, i.e., home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative and appropriate for the active treatment of a condition, illness, disease, or injury* • *Services provided by a family member or resident in the member's home*	*All charges*
Chiropractic	
30 visits per calendar year	Network: 20% of our allowance Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount.
Alternative medicine treatments	
No benefit	*All charges*
Educational classes and programs	
• Tobacco cessation programs includes: - Individual group/phone counseling - Physician prescribed over the counter (OTC) and prescription drugs approved by the FDA to treat nicotine dependence Note: See Section 5(f) Prescription benefits for information on physician prescribed OTC and prescription drugs approved by the FDA to treat tobacco cessation. See Section 5(e) for information on individual and group psychotherapy.	Nothing
• Diabetes - Self-management training and education performed in-person; including medical nutrition therapy, when provided by a certified, licensed, or registered healthcare professional.	Network: 20% of our allowance Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount.

Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Healthcare Professionals

Important things you should keep in mind about these benefits:

- YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- The network deductibleis $1,500 per Self enrollment ($3,000 per Self Plus One enrollment, or $3,000 per Self and Family enrollment). The out-of-network deductible is $2,500 per Self enrollment ($5,000 per Self Plus One enrollment, or $5,000 per Self and Family enrollment). The deductible applies to almost all benefits under Traditional medical coverage. You must pay your deductible before your Traditional medical coverage may begin. The deductible applies to all benefits in this Section unless we indicate differently.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your deductible, coinsurance or copayments amounts for eligible medical expenses and prescriptions.
- The services listed below are for the charges billed by a physicianor other healthcare professional for your surgical care. See Section 5(c) for charges associated with a facility (i.e. hospital, surgical center, etc.).

Benefit Description	You pay After the calendar year deductible…
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) • Voluntary sterilization for men (e.g., vasectomy) • Insertion of internal prosthetic devices. See 5(a) – *Orthopedic and prosthetic devices* for device coverage information Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker. • Surgical treatment of morbid obesity (bariatric surgery) – a condition in which an individual has a body mass index (BMI) exceeding 40 or a BMI greater than 35 in conjunction with documented significant co-morbid conditions (such as diabetes , cardiovascular disease, hypertension or life threatening cardio-pulmonary problems).** - Members must have:	Network: 20% of our allowance Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible…
Surgical procedures (cont.)	
• Past participation in a weight loss program; **and** • Inadequate weight loss despite a committed attempt at conservative medical therapy (for example, comprehensive lifestyle interventions, including a combination of diet, exercise, and behavioral modifications); **and** • Pre-operative medical *and* mental health evaluations and clearances; **and** • Pre-operative education which addresses the risks, benefits, realistic expectations and the need for long-term follow-up and adherence to behavioral modifications; **and** • A treatment plan which addresses the pre and post-operative needs of an individual undergoing bariatric surgery.	Network: 20% of our allowance Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount
Not covered: • *Reversal of voluntary sterilization*	*All charges*
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital and developmental anomalies are cleft lip, cleft palate, webbed fingers, and webbed toes. All surgical requests must be preauthorized. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts - treatment of any physical complications, such as lymphedema - breast prostheses and surgical bras and replacements (*see Prosthetic devices*) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	Network: 20% of our allowance Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount
Gender Reassignment Surgical services to treat gender dysphoria. The following procedures will be covered once medical necessity criteria and precertification has been met: • Surgeries consisting of any combination of the following: hysterectomy, salpingo-oophorectomy, ovariectomy, or orchiectomy; or	Network: 20% of our allowance Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount

Reconstructive surgery - continued on next page

Benefit Description	You pay After the calendar year deductible…
Reconstructive surgery (cont.)	
• Surgeries consisting of any combination of the following: metoidioplasty, phalloplasty, vaginoplasty, penectomy, clitoroplasty, labiaplasty, vaginectomy, scrotoplasty, urethroplasty, or placement of testicular prostheses; or • Bilateral mastectomy Note: For more information please contact customer service.	Network: 20% of our allowance Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form and for which the disfigurement is not associated with functional impairment, except repair of accidental injury* • *Cosmetic procedures include but not limited to: Abdominoplasty, blepharoplasty, breast augmentation, brow lift, calf implants, electrolysis, face lift, facial bone reconstruction, facial implants, gluteal augmentation, hair removal/hairplasty, jaw reduction (jaw contouring), lip reduction/enhancement, lipofilling/collagen injections, liposuction, nose implants, pectoral implants, rhinoplasty, thyroid cartilage reduction (chondroplasty), voice modification surgery, voice therapy*	*All charges*
Oral and maxillofacial surgery	
Oral surgeries limited to: • Treatment of medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia • Maxillary or mandibular frenectomy when not related to a dental procedure • Alveolectomy when related to tooth extraction • Orthognathic surgery because of a medical condition or injury or for a physical abnormality that prevents normal function of the joint or bone and 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 • Treatment of non-dental lesions, such as removal of tumors and biopsies • Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses • Treatment of temporomandibular (TMJ) disorders	Network: 20% of our allowance Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount
Not covered: • *Dental implants* • *Dental care (such as restorations) involved with the treatment of temporomandibular joint (TMJ) pain dysfunction syndrome* • *Fixed or removable appliances that involve movement or repositioning of the teeth, repair of teeth, or prosthetics for TMJ*	*All charges*

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants	
These **solid organ transplants** are subject to medical necessity and experimental/ investigational review by the Plan. See Section 3. Other services under You need prior Plan approval for certain services. Solid organ transplants are limited to: • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Cornea • Heart • Heart-lung • Intestinal transplants - Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs such as the liver, stomach, and pancreas • Kidney • Kidney-pancreas • Liver • Lung - single/bilateral/lobar • Pancreas	Network: 20% of our allowance Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount
Tandem transplants for covered transplants: subject to medical necessity review by the Plan. Autologous tandem transplants for • AL Amyloidosis • Multiple myeloma (de novo and treated) • Recurrent germ cell tumors (including testicular cancer)	Network: 20% of our allowance Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount
Blood or marrow stem cell transplants The Plan extends coverage for the diagnoses as indicated below. • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow Failure and Related Disorders (i.e. Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic Syndromes	Network: 20% of our allowance Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
- Paroxysmal Nocturnal Hemoglobinuria deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma recurrence - relapsed or refractory - Advanced Non-Hodgkin's lymphoma recurrence - relapsed or refractory - Amyloidosis - Breast Cancer - Epithelial ovarian cancer - Neuroblastoma	Network: 20% of our allowance Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount
Mini-transplants performed in a Clinical Trial Setting (non-myeloablative, reduced intensity conditioning for members with a diagnosis listed below: Subject to Medical Necessity. • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Hodgkin's lymphoma – relapsed - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic Syndromes - Non-Hodgkin's lymphoma – relapsed - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for: - Amyloidosis - Hodgkin's lymphoma – relapsed - Neuroblastoma - Non-Hodgkin's lymphoma – relapsed	Network: 20% of our allowance Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount
Blood or Marrow Stem Cell Transplants Not subject to medical necessity:	Network: 20% of our allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
Allogeneic transplant for: • Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) Autologous transplants for: • Multiple myeloma • Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors	Network: 20% of our allowance Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount
Blood or Marrow Stem Cell Transplants: Not Subject to Medical Necessity. May Be Limited to Clinical Trials. Autologous transplants for: • Advanced childhood kidney cancers • Advanced Ewing sarcoma • Aggressive non-Hodgkin's lymphomas (Mantle Cell lymphoma, adult T-cell leukemia/lymphoma, peripheral T-cell lymphomas and aggressive Dendritic Cell neoplasms) • Breast cancer • Childhood rhabdomyosarcoma • Epithelial ovarian cancer • Mantle Cell (Non-Hodgkin lymphoma)	Network: 20% of our allowance Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount
Blood or Marrow Stem Cell Transplants under clinical trials. Allogeneic transplants for: • Beta Thalassemia Major • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Multiple myeloma (after a previous autologous stem cell transplant or due to primary graft failure, failure to engraft or rejection) • Multiple sclerosis* • Sickle cell Non-myeloablative allogeneic transplants for: • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma • Advanced Non-Hodgkin's lymphoma - relapsed or refractory • Chronic lymphocytic leukemia • Chronic lymphocytic lymphoma/small lymphoma (CLL/SLL) - relapsed/refractory disease • Chronic myelogenous leukemia • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Multiple myeloma (after a previous autologous stem cell transplant or due to primary graft failure, failure to engraft or rejection)	Network: 20% of our allowance Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
• Multiple sclerosis* • Myelodysplasia/Myelodysplastic Syndromes • Myeloproliferative Disorders • Sickle Cell disease Autologous transplants for the following autoimmune diseases: • Multiple sclerosis* • Scleroderma* • Scleroderma-SSc (severe, progressive)* • Systemic lupus erythematosus* • Systemic sclerosis* Autologous transplants for: • Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) (after allogeneic transplant)* • Chronic myelogenous Leukemia (after allogeneic transplant)* • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma (after allogeneic transplant)* *Procedures require review for medical necessity and benefit determination by an external medical director.	Network: 20% of our allowance Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount
Blood or Marrow Stem Cell Transplants Allogeneic transplants for: • Infantile malignant osteopetrosis • Kostmann's syndrome • Leukocyte adhesion deficiencies • Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) • Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants) • Myeloproliferative disorders • Sickle cell anemia • X-linked lymphoproliferative syndrome Autologous transplants for: • Ependymoblastoma • Ewing's sarcoma • Medulloblastoma • Pineoblastoma • Waldenstrom's macroglobulinemia	Network: 20% of our allowance Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount
National Transplant Program (NTP) - We are a member of the Blue Distinction Center for Transplants.	

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
All care for transplants must be coordinated through HealthKeepers in writing. The physician should send a letter to the HealthKeepers Medical Director requesting precertification. We will cover up to $10,000 of reasonable and necessary travel costs when you get prior approval and need to travel more than 75 miles from your permanent home to reach the Facility where the Covered Transplant Procedure will be performed. For lodging and ground transportation benefits, we will cover costs up to the current limits set forth in the Internal Revenue Code.	
Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four allogenic bone marrow/stem cell transplant donors in addition to the testing of family members.	Network: 20% of our allowance Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount
Not covered: • *Implants of artificial organs* • *Transplants not listed as covered* • *Donor screening tests and donor search expenses, except as shown above*	*All charges*
Anesthesia	
Professional services provided in: • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office Note: Benefits are provided only for the administration of general anesthesia, for both hospital and office charges, occurring in connection with dental services provided for the following members: • Children through age 4; • Severely disabled people; and • People with medical or behavioral conditions that require hospitalization or general anesthesia for dental care Note: The dental procedures themselves are not covered.	Network: 20% of our allowance Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount

Section 5(c). Services Provided by a Hospital or Other Facility, and Ambulance Services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The network deductible is $1,500 per Self enrollment ($3,000 per Self Plus One enrollment, or $3,000 per Self and Family enrollment). The out-of-network deductible is $2,500 per Self enrollment ($5,000 per Self Plus One enrollment, or $5,000 per Self and Family enrollment). The deductible applies to almost all benefits under Traditional medical coverage. You must pay your deductible before your Traditional medical coverage may begin. The deductible applies to all benefits in this Section unless we indicate differently.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your deductible, coinsurance or copayments amounts for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospitalor surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You Pay After the calendar year deductible...
Inpatient hospital	
Room and board, such as • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	Network: 20% of our allowance Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount
Other hospital services and supplies, such as: • Operating, childbirth, and treatment rooms and equipment • Prescribed drugs and medications • Anesthesia, anesthesia supplies and services • Medical supplies and equipment • Blood and blood products • Diagnostic services • Therapy services, including infusion therapy services	Network: 20% of our allowance Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount
Not covered: • *Non-covered facilities, such as nursing homes, schools* • *Custodial care, rest cures, domiciliary or convalescent cares*	*All charges*

Inpatient hospital - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Inpatient hospital (cont.)	
• *Personal comfort items, such as a phone, television, barber service, guest meals and beds* • *Private nursing care*	*All charges*
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Prescribed drugs and medications • Radiologic procedures, diagnostic laboratory tests, and X-rays • Pathology Services • Administration of blood, blood plasma, and other biologicals • Blood products, derivatives and components, artificial blood products and biological serum • Dressings, casts, and sterile tray services • Pre-surgical testing • Medical supplies, including oxygen • Anesthetics and anesthesia service • CT/CAT Scans, MRI, MRA, PET, nuclear cardiology imaging studies and non-maternity related ultrasounds • Other non-surgical care Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	Network: 20% of our allowance Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount
Extended care benefits/Skilled nursing care facility benefits	
Extended care for a combined total of 150 days per calendar year. • Extended care/skilled nursing facility • Inpatient days for physical medicine and rehabilitation	Network: 20% of our allowance Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount
Not covered: • *Custodial care*	*All charges*
Hospice care	
Care given for terminally ill and likely have less than twelve (12) months to live. Care is covered when given by a Hospice for palliative care of pain or other symptoms that are part of a terminal disease. Covered services include: • Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care.	Network: 20% of our allowance Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount

Hospice care - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Hospice care (cont.)	
• Short-term Inpatient Hospital care when needed in periods of crisis or as respite care. Coverage includes short-term inpatient care, including both respite care and procedures necessary for pain control and acute chronic symptom management. Respite care means non-acute inpatient care for the covered person in order to provide the covered person's primary caregiver a temporary break from caregiving responsibilities. • Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse. • Social services and counseling services from a licensed social worker. • Nutritional support such as intravenous feeding and feeding tubes. • Physical therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist. • Pharmaceuticals, medical equipment, and supplies needed for pain management and the palliative care of your condition, including oxygen and related respiratory therapy supplies. • Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Member's death. Bereavement services are available to the patient and those individuals who are closely linked to the patient, including the immediate family, the primary or designated care giver and individuals with significant personal ties for one year after the Member's death.	Network: 20% of our allowance Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount
Not covered: • *Independent nursing* • *Homemaker services*	*All charges*
Ambulance	
Medically Necessary ambulance services are a Covered Service when: • You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation And one or more of the following criteria are met; • For ground ambulance, you are taken: - From your home, the scene of an accident or medical Emergency to a Hospital; - Between Hospitals, including when we require you to move from an Out-of-Network Hospital to a Network Hospital; - Between a Hospital and a Skilled Nursing Facility or other approved Facility • For air or water ambulance, you are taken: - From the scene of an accident or medical Emergency to a Hospital;	20% of our allowance

Ambulance - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Ambulance (cont.)	
- Between Hospitals, including when we require you to move from an Out-of-Network Hospital to a Network Hospital; - Between a Hospital and an approved Facility. Note: Benefits are only available for air ambulance when it is not appropriate to use a ground or water ambulance. If you are moving from one Hospital to another, air ambulance will only be covered if using a ground ambulance would endanger your health and if the Hospital that first treats cannot give you the medical services you need.	20% of our allowance
Not covered: • *Trips to a doctor's office, clinic, morgue or funeral home*	*All charges*

Section 5(d). Emergency Services/Accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Your catastrophic out-of-pocket maximum for network services is $5,000 per Self enrollment, $10,000 for Self Plus One enrollment or $10,000 for Self and Family enrollment per calendar year. The catastrophic out-of-pocket maximum for out-of-network services is $7,000 per Self enrollment, $14,000 per Self Plus One enrollment or $14,000 per Self and Family enrollment. However, certain expenses do not count toward your out-of-network pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's benefit maximum, or amounts in excess of the Plan allowance).
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your deductible, coinsurance or copayments amounts for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- When you need emergency medical care outside of the U.S., go to the nearest hospital. Call the Placard Worldwide Service Center at 800-810-BLUE (2583), or call collect at 804-673-1177, if you are admitted.

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

If you need emergency care, you are covered 24 hours a day, 7 days a week, anywhere in the world. An emergency medical condition is one manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the person's health, or with respect to a pregnant woman, the health of the woman and her unborn child. If you are admitted to an inpatient facility, you or a family member or friend on your behalf should notify HealthKeepers as soon as possible.

Emergencies within our service area

If possible, when an unexpected condition arises, call your network physician – unless you believe any delay would be harmful. This applies even if it's after office hours. Your network physician will tell you whether to go to the emergency room.

If you need additional care after an emergency condition is stabilized, precertification is required. Your Anthem HealthKeepers physician will handle this for you. We will make a decision about the care within 30 minutes after we receive all the necessary information.

When you need care right away but it is not an emergency, always call a network physician first. The network physician may have you come into the office for an urgent appointment. An urgent appointment is one scheduled with a network physician for the same day or during hours not normally used for appointments.

Emergencies outside our service area

If possible, when an unexpected condition arises, call your network physician unless you believe any delay would be harmful. This applies even if it's after office hours. Your network physician will tell you whether to go to the emergency room.

If you need additional care after an emergency condition is stabilized, precertification is required. We will make a decision about the care within 30 minutes after we receive all the necessary information.

If you are admitted as an inpatient in a non-network hospital as a result of an emergency, you, your doctor or a family member should call Anthem HealthKeepers as soon as possible for precertification of the case.

When you need care right away, but it is not an emergency, always call your network physician. Your network physician may have you come into the office for an urgent appointment. An urgent appointment is one scheduled with a network physician for the same day or during hours not normally used for appointments.

After Hours Care

If you need care after normal business hours, your Doctor may have several options for you. You should call your Doctor's office for instructions if you need care in the evenings, on weekends, or during the holidays and cannot wait until the office reopens. If you have an Emergency, call 911 or go to the nearest Emergency Room.

Benefit Description	You pay After the calendar year deductible…
Emergency within our service area	
• Emergency or urgent care at a doctor's office • Emergency or urgent care at an urgent care center • Emergency care as an outpatient in a hospital, including doctors' services • Hospital observation Note: If you need follow-up care after emergency treatment, call your network physician.	20% of our allowance
Not covered: • *Elective or non-emergency care*	*All charges*
Emergency outside our service area	
• Emergency or urgent care at a doctor's office • Emergency or urgent care at an urgent care center • Emergency care as an outpatient in a hospital, including doctors' services • Hospital observation Note: If you need follow-up care after emergency treatment, call your network physician.	20% of our allowance
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area*	*All charges*

Benefit Description	You pay After the calendar year deductible…
Ambulance	
Medically Necessary ambulance services are a Covered Service when: • You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation And one or more of the following criteria are met: • For ground ambulance, you are taken: - From your home, the scene of an accident or medical Emergency to a Hospital; - Between Hospitals, including when we require you to move from an Out-of-Network Hospital to a Network Hospital; - Between a Hospital and a Skilled Nursing Facility or other approved Facility. • For air or water ambulance, you are taken: - From the scene of an accident or medical Emergency to a Hospital; - Between Hospitals, including when we require you to move from an Out-of-Network Hospital to a Network Hospital; - Between a Hospital and an approved Facility. Note: Benefits are only available for air ambulance when it is not appropriate to use a ground or water ambulance. If you are moving from one Hospital to another, air ambulance will only be covered if using a ground ambulance would endanger your health and if the Hospital that first treats cannot give you the medical services you need.	20% of our allowance
Not covered: • *Trips to a doctor's office, clinic, morgue or funeral home*	*All charges*

Section 5(e). Mental Health and Substance Use Disorder Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In order for network benefits to apply, Plan physicians must provide or arrange your care within the network.
- Your catastrophic out-of-pocket maximum for network services is $5,000 per Self enrollment, $10,000 for Self Plus One enrollment or $10,000 for Self and Family enrollment per calendar year. The catastrophic out-of-pocket maximum for out-of-network services is $7,000 per Self enrollment, $14,000 per Self Plus One enrollment or $14,000 per Self and Family enrollment. However, certain expenses do not count toward your out-of-network pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's benefit maximum, or amounts in excess of the Plan allowance).
- Pre-approval or precertification must be obtained if Non-Network providers are used.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **CERTAIN SERVICES REQUIRE PREAUTHORIZATION.** Please refer to the precertification information shown in Section 3 to be sure which services require preauthorization. Under the Anthem HealthKeepers plan non-network benefits, you are ultimately responsible for ensuring that we have approved or precertified the services.

Benefit Description	You pay After the calendar year deductible…
Professional services	
We cover professional services by licensed professional mental health and substance use disorder treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of substance use disorders, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy • Intensive in-home behavioral health services, when available in your area. These services do not require confinement to the home • Inpatient hospital physician visit	Network: 20% of our allowance Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount

Professional services - continued on next page

Benefit Description	You pay After the calendar year deductible…
Professional services (cont.)	
• Preferred provider online and other online visits	Network: 20% of our allowance Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount
• Individual and group psychotherapy for the treatment of tobacco cessation	Network: 20% of our allowance Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount
Diagnostics	
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance use disorder treatment practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	Network: 20% of our allowance Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount
Inpatient hospital or other covered facility	
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services • Residential treatment centers	Network: 20% of our allowance Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount
Outpatient hospital or other covered facility	
Outpatient services provided and billed by a hospital or other covered facility • Services such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment	Network: 20% of our allowance Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount
Not covered	
• *Marital counseling*	*All charges*

Section 5(f). Prescription Drug Benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart under *Covered medications and supplies*.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Federal law prevents the pharmacy from accepting unused medications.
- Members must make sure their prescribers obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- Your catastrophic out-of-pocket maximum for network services is $5,000 per Self enrollment, $10,000 for Self Plus One enrollment or $10,000 for Self and Family enrollment per calendar year. The catastrophic out-of-pocket maximum for out-of-network services is $7,000 per Self enrollment, $14,000 per Self Plus One enrollment or $14,000 per Self and Family enrollment. However, certain expenses do not count toward your out-of-network pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's benefit maximum, or amounts in excess of the Plan allowance).
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your deductible, coinsurance or copayments amounts for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed/certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medication.
- **Where you can obtain them.** You may fill the prescription at a Plan pharmacy, by mail or from our Specialty Pharmacy. When using a plan pharmacy, you have two levels to choose from. Level 1 pharmacies will have lower copayments and Level 2 pharmacies will have higher copayments. Call us at 855-580-1200 or visit our website at www.anthem.com for information on how to obtain a listing of the Level 1 and Level 2 pharmacies. To find out if a certain drug is available by mail order, call the Pharmacy Member Services number on the back of your identification card.
- **We use a formulary.** We also have a Prescription Drug List, (a formulary), which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness. Our formulary is called the Essential Formulary and benefits may not be covered for certain Drugs if they are not on the Essential Formulary Prescription Drug List.

  You may request a copy of the covered Prescription Drug list by calling the Member Services telephone number on the back of your Identification Card or visiting our website at www.anthem.com. The covered Prescription Drug list is subject to periodic review and amendment. Inclusion of a Drug or related item on the covered Prescription Drug list is not a guarantee of coverage.

  Please contact the Pharmacy Member Services number on the back of your card for information regarding the exception process.

- **These are the dispensing limitations**. Prescription drugs prescribed by a Plan or referral doctor and obtained at a Plan pharmacy will be dispensed for up to a 30-day supply for retail or one commercially prepared unit (i.e., one inhaler, one vial ophthalmic medication or insulin); and are available under the Anthem HealthKeepers plan. Mail order prescription drugs are dispensed for up to a 90-day supply, and are also available under the Anthem HealthKeepers plan, If a member is called to active military duty, or in times of national or other emergency, call us to arrange for a medium-term supply of covered medications. Early refills of prescription eye drops will be allowed if authorized by the prescribing Provider and we are notified.
- **A generic equivalent will be dispensed if it is available**, Generic substitution is a process by which a generic equivalent is dispensed instead of a brand name product. Anthem mandates generic substitution for brand drugs that have generic equivalents that are "A-rated" by the Food and Drug Administration (FDA).
- **Why use generic drugs?** ? Generic drugs normally cost considerably less than brand name drugs. So, the copayment you pay for generic drugs is also lower. The generic name of a drug is its chemical name. The brand name is the trade name under which the drug is advertised and sold. By law, generic and brand name drugs must meet the same standards for safety, purity, strength and effectiveness. They are dispensed in the same dosage and taken in the same way.
- **When you do have to file a claim.** Send your itemized bill(s) to:

Benefit Description	You pay After the calendar year deductible…
Covered medications and supplies	
We cover the following medications and supplies prescribed by your licensed attending physician or dentist and obtained from a Plan pharmacy or through our mail order program or an out-of-network retail pharmacy: • Drugs and medications that by Federal law of the United States require a physician's prescription for their purchase, except those listed as Not covered • Self-injectable drugs • Disposable needles and syringes for the administration of covered medications • Diabetic supplies • Prenatal vitamins (as covered under the Plan's formulary) • Immunizations required by the Preventive Care Services benefit • Off label use of covered drugs if prescribed by a Plan physician • Drugs to treat gender dysphoria (Certain hormone therapies may require prior authorization, contact the pharmacy member services phone number on the back of your identification card) Note: • You may also obtain a 90-day supply of Maintenance Medications from a Maintenance Pharmacy. If you are not sure the Prescription Drug you are taking is a Maintenance Medication or need to determine if your Pharmacy is a Maintenance Pharmacy, please call Member Services at the number on the back of your Identification Card or check our website at anthem.com for more details. • Refills your doctor authorizes are covered for up to 12 months from the original prescription date. Then a new prescription is required. • **Specialty drugs must be obtained through the Specialty Pharmacy Program.** You cannot obtain specialty drugs from a retail pharmacy unless we have granted an exception.	**Network:** **Level 1 Retail (up to a 30-day supply)** Tier 1 - $10 Tier 2 - $40 Tier 3 - $70 **Level 2 Retail (up to a 30-day supply)** Tier 1 - $20 Tier 2 - $50 Tier 3 - $80 **Tier 4** - 25% of our allowance up to a maximum out-of-pocket of $300 per prescription order for a 30-day supply **Mail order and online (up to a 90-day supply):** Tier 1 - $25 Tier 2 - $100 Tier 3 - $175 **Out-of-Network** 30% of our allowance

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible…
Covered medications and supplies (cont.)	
• Prescription drugs that contain insulin and used to treat diabetes	Up to a $50 copay per 30-day supply or up to a $150 copay per 90-day supply. Network deductible does not apply.
• FDA approved drugs for the treatment of tobacco cessation. Note: This includes prescription and physician prescribed over-the-counter medications.	**Network:** Nothing (No deductible) 30% of our allowance
Women's contraceptive drugs and devices • Self-administered • Oral • Self-injectable • Patches • Rings Note: Up to a 12-month supply of FDA approved self-administered hormonal contraceptives when dispensed or furnished at one time by a provider or pharmacist, or at a location licensed or otherwise authorized to dispense drugs or supplies.	**Network:** Nothing (No deductible) **Out-of-Network:** 30% of our allowance
Not covered: • *Prescription drugs dispensed by any mail service program other than the PBM's mail service* • *Drugs, devices and products, or prescription legend drugs with over-the-counter equivalents and any drugs, devices or products that are therapeutically comparable to an over-the-counter drug, device, or product. This exclusion does not apply to over-the-counter products that we must cover as a preventive care service* • *Drugs not approved by the FDA* • *Any drug that is primarily for weight loss (except when authorized for the treatment of morbid obesity)* • *Fertility drugs* • *Refills of lost or stolen medications*	*All charges*
Preventive care medications	
Medications to promote better health as recommended by ACA. Drugs and supplements are covered without cost-share which includes over-the-counter, are prescribed by a healthcare professional and filled at a network pharmacy. This list includes but is not limited to: • Aspirin (81 mg) for men age 45-79 and women age 55-79 and women of childbearing age • Folic acid supplements for women of childbearing age 400 & 800 mcg • Pre-natal vitamins for pregnant women • Fluoride tablets, solution (not toothpaste, rinses) for children age 0-6	**Network:** Nothing (No deductible) **Out-of-network (retail pharmacies only):** 30% of our allowance

Preventive care medications - continued on next page

Benefit Description	You pay After the calendar year deductible…
Preventive care medications (cont.)	
Note: To receive this benefit a prescription from a doctor must be presented to pharmacy.	**Network:** Nothing (No deductible) **Out-of-network (retail pharmacies only):** 30% of our allowance
Preventive drugs for the following conditions: • Congestive heart failure • CAD • Osteoporosis and/or osteopenia • Asthma • Diabetes • Depression • Heart disease Note: You may obtain a copy of the drug list by calling the customer service number on the back of your identification card or visit the web site at https://www.anthem.com/ms/pharmacyinformation/home.html.	**Network:** Nothing (No deductible) **Out-of-network (retail pharmacies only):** 30% of our allowance

Section 5(g). Dental Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Your catastrophic out-of-pocket maximum for network services is $5,000 per Self enrollment, $10,000 for Self Plus One enrollment or $10,000 for Self and Family enrollment per calendar year. The catastrophic out-of-pocket maximum for out-of-network services is $7,000 per Self enrollment, $14,000 per Self Plus One enrollment or $14,000 per Self and Family enrollment. However, certain expenses do not count toward your out-of-network pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's benefit maximum, or amounts in excess of the Plan allowance).
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts and copayments for eligible medical expenses and prescriptions.
- Under your Traditional medical coverage, you will be responsible for your deductible, coinsurance or copayments amounts for eligible medical expenses and prescriptions.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You Pay After the calendar year deductible...
Accidental injury benefit	
We cover dental work needed to treat injuries to the jaw, teeth, mouth or face as a result of an accident. An injury that results from chewing or biting is not considered an Accidental Injury under this Plan, unless the chewing or biting results from a medical or mental condition. Dental appliances required to diagnose or treat an accidental injury to the teeth, and the repair of dental appliances damaged as a result of accidental injury to the jaw, mouth or face, are also covered.	Network: 20% of our allowance Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount
Dental benefits	
We have no other dental benefits.	*All charges*

Section 5(h). Wellness and Other Special Features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
24 hour nurse line	For any of your health concerns, 24 hours a day, 7 days a week, you may call and talk with a registered nurse who will discuss treatment options and answer your health questions. Simply call the toll-free number on the back of your Identification card.
Reciprocity benefit	**Guest Memberships** When you or any of your covered Dependents will be staying temporarily outside of the Service Area for more than 90 days, you can request a guest membership to a Blue Cross and Blue Shield affiliated health maintenance organization in that area. An example of when this service may be utilized is when a Dependent student attends a school outside of the Service Area. Call Member Services at the number on the back of your identification card to make sure that the area in which you or your Dependents are staying is within the Guest Membership Network. **BlueCard® Program** With the BlueCard® Program, Plan members have access to benefits when traveling outside the Plan's service area for urgent care and emergency room services. To find a nearby healthcare provider, members can simply call BlueCard Access at 800-810-BLUE (2583).
Centers of excellence	We use the Blue Distinction Center for Transplants as our transplant network. The network consists of leading medical facilities throughout the nation. For a list of transplant hospitals near you, call 800-824-0581. Blue Distinction Centers for Cardiac Care provide a full range of cardiac care services, including inpatient cardiac care, cardiac rehabilitation, cardiac catheterization and cardiac surgery (including coronary artery bypass graft surgery). To date, we have designated more than 410 Blue Distinction Centers for Cardiac Care across the country.

Section 5(i). Health Education Resources and Account Management Tools

Special features	Description
Health education resources	We keep you informed on a variety of issues related to your good health. Visit our website at www.anthem.com or call Member Services at 855-580-1200 for information on: • HealthKeepers member website • Online provider directory • Information on Sydney, out mobile app • Cost of care tools • Where to go for care • Preventive care guidelines
Account management tools	For each HSA and HRA account holder, we maintain a complete claims payment history online through www.anthem.com. • Register online at www.anthem.com • Select the My Plans tab • Select Spending Accounts Your balance will also be shown on your explanation of benefits (EOB) form. You will receive an EOB after every claim.
Consumer choice information	As a member of this HDHP, you may choose any licensed provider. However, you will less out-of-pocket costs when you see a network provider. Directories are available online by going to the HealthKeepers website at www.anthem.com. Pricing information for: • Medical care • Prescription drugs Online provider searches for: • Medical providers • Pharmacies Educational materials on the topics of HSAs, HRAs and HDHPs.
Care support	Patient safety information is available online at www.anthem.com

Non-FEHB Benefits Available to Plan Members

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

Discount programs

You can receive negotiated savings on selected health and wellness services and programs simply by being an eligible HealthKeepers member. To obtain information about these programs please call us at 855-580-1200 or visit our website at www.anthem.com. Examples of the programs that may be available are:

- Puritan's Pride – discounts on various vitamins, minerals and supplements
- LivingFree - discount on smoking cessation classes
- LivingEasy - discounts on stress management programs
- LivingLean – discounts on weight-loss programs
- LifeMart - deals on beauty/skin care, diet plans, fitness clubs, spas and more
- Safebeginnings – discounts on baby-proofing products
- EyeMed – discounts on glasses and accessories
- TruVision – preferred pricing on LASIK eye surgery
- Global Fit – discounts on gym memberships, fitness equipment, coaching and more

Anthem Protect short-term disability insurance
Income protection exclusively for federal employees

Plan Highlights:

- Flexible design; customize insurance plan and benefits specific to your budget and life circumstances.
- Guaranteed acceptance; federal employees are eligible regardless of health history
- Quick-and-easy enrollment process
- Lump-sum cash benefits provided if you suffer a covered disability

Who is eligible?

An applicant is eligible for Anthem Protect short-term disability insurance if they are a federal civilian employee working in the United States for a minimum of 20 hours per week. Applicant can enroll in insurance during the annual open enrollment period or within 60 days from date they become eligible.

Make sure help is available when you need it!

Questions? Please contact the number listed on your identification card or visit anthem.com/federal to sign up today.

Section 6. General Exclusions – Services, Drugs and Supplies We do not Cover

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

We do not cover the following:

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

Section 7. Filing a Claim for Covered Services

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

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

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

Medical and hospital benefits

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

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

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

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

Submit your claims to:
HealthKeepers
P.O. Box 27401
Richmond, VA 23279

Prescription drugs

Major chains and independent pharmacies belong to your pharmacy network. At these pharmacies, if you show your HealthKeepers identification card, you should only be responsible for paying your share of the cost. The pharmacy should file your claim, and we will pay the pharmacy directly.

At a Non-Network Pharmacy: If you go to a non-network pharmacy in an urgent or emergency situation outside the HealthKeepers service area, you are responsible for paying for your prescription at the time of service and then filing a claim. Your program will not provide benefits if you use a non-network pharmacy within the HealthKeepers service area.

You can obtain a Prescription Drug Claim Form by calling Client Services at 855-580-1200.

You can file up to three prescriptions on each form. Please do not use a regular health benefits claim form to file your prescription drug claim. If you do, your claim may be denied.

- Please fill out a separate claim form for each person and pharmacy.
- Be sure to provide all the information requested for each prescription. You may need to have the pharmacy complete the form or get the information from the pharmacy.
- Then you or the pharmacist should fill out the pharmacy's name, address and National Association of Board of Pharmacy (NABP) number.
- On the completed form, tape your original itemized prescription drug receipt(s). Please do not send cash register receipts, canceled checks, bottle labels, copies of the original prescription drug receipts, or your own itemization of charges.The receipt(s) must show: the prescription number, the patient's name, the name of the drug, the quantity and unit dose, and the strength of the drug.

Sign the claim form and mail it along with your receipt(s) to the address shown below:

Claims Department
P.O. Box 52065
Phoenix, AZ 85072-2065

Deadline for filing your claim

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

Post-service claims procedures

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

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

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

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond. Our deadline for responding to your claim is stayed while we await all of the additional information needed to process your claim.

Authorized Representative

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

Notice Requirements

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

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

Section 8. The Disputed Claims Process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please call your plan's customer service representative at the phone number found on your enrollment card, plan brochure, or plan website.

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

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing HealthKeepers, 3075 Vandercar Way, OH3402-B014, Cincinnati, OH 45209 or calling 855-580-1200.

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

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

Our reconsideration will not take into account the initial decision. The review will not be conducted by the same person, or their subordinate, who made the initial decision.

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

Disagreements between you and the HDHP fiduciary regarding the administration of an HSA or HRA are not subject to the disputed claims process.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: HealthKeepers, Mail No. OH3402-B014, 3075 Vandercar Way, Cincinnati, OH 45209; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.

2	In the case of a post-service claim, we have 30 days from the date we receive your request to: a) Pay the claim or b) Write to you and maintain our denial or c) Ask you or your provider for more information. You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
3	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us--if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, FEHB 2, 1900 E Street, NW, Washington, DC 20415-3630. Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call. • Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly. Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim. Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a healthcare professional with knowledge of your medical condition may act as your authorized representative without your express consent. Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond our control.
4	OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

	If you do not agree with OPM's decision, your only recourse is to sue. If you decide to file a lawsuit, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended. OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record. You may not file a lawsuit until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

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

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

Section 9. Coordinating Benefits with Medicare and Other Coverage

When you have other health coverage

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

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

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

When we are the secondary payor, we will determine our allowance. After the primary Plan pays, we will pay what is left of our allowance, up to our regular benefit. All programs together will not pay more than 100% of allowable expenses. The allowable expense is the maximum amount that a Plan will pay for covered services. We will not pay more than our allowance.

- **TRICARE and CHAMPVA**

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

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

- **Workers' Compensation**

We do not cover services that:

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

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

- **Medicaid**

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

Our right to pursue and receive subrogation and reimbursement recoveries is a condition of, and a limitation on, the nature of benefits or benefit payments and on the provision of benefits under our coverage.

If you have received benefits or benefit payments as a result of an injury or illness and you or your representatives, heirs, administrators, successors, or assignees receive payment from any party that may be liable, a third party's insurance policies, your own insurance policies, or a workers' compensation program or policy, you must reimburse us out of that payment. Our right of reimbursement extends to any payment received by settlement, judgment, or otherwise.

We are entitled to reimbursement to the extent of the benefits we have paid or provided in connection with your injury or illness. However, we will cover the cost of treatment that exceeds the amount of the payment you received.

Reimbursement to us out of the payment shall take first priority (before any of the rights of any other parties are honored) and is not impacted by how the judgment, settlement, or other recovery is characterized, designated, or apportioned. Our right of reimbursement is not subject to reduction based on attorney fees or costs under the "common fund" doctrine and is fully enforceable regardless of whether you are "made whole" or fully compensated for the full amount of damages claimed.

We may, at our option, choose to exercise our right of subrogation and pursue a recovery from any liable party as successor to your rights.

If you do pursue a claim or case related to your injury or illness, you must promptly notify us and cooperate with our reimbursement or subrogation efforts.

This Plan always pays secondary to:

- Any medical payment, PIP or No-Fault coverage under any automobile policy available to you.
- Any plan or program which is required by law.

You should review your automobile insurance policy to ensure that uncoordinated medical benefits have been chosen so that the automobile insurance policy is the primary payer.

Note: For Motor Vehicle Accidents, charges incurred due to injuries received in an accident involving any motor vehicle for which no-fault insurance is available are excluded from coverage, regardless of whether any such no-fault policy is designated as secondary to health coverage.

For a complete explanation on how the Plan is authorized to operate when others are responsible for your injuries please go to: www.anthem.com.

Note: If the Plan recovers money through subrogation, the Medical Fund will not be reimbursed.

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

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com or by phone 877-888-3337 (TTY 877-889-5680), you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical trials

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

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

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

When you have Medicare

For more detailed information on "What is Medicare?" and "Should I Enroll in Medicare?" please contact Medicare at 800-MEDICARE (800-633-4227), (TTY 1-877-486-2048) or at www.medicare.gov.

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

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

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

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

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

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

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

Please review the following table it illustrates your cost share if you are enrolled in Medicare Part B.

Benefit Description: Deductible

High Option You pay without Medicare: $1,500/$3,000/$3,000
High Option You pay with Medicare Part B: $1,500/$3,000/$3,000

Benefit Description: Catastrophic Protection Out-of-Pocket Maximum

High Option You pay without Medicare: $5,000/$10,000/$10,000
High Option You pay with Medicare Part B: $5,000/$10,000/$10,000

Benefit Description: Primary Care Physician

High Option You pay without Medicare: After calendar deductible 20% of our allowance
High Option You pay with Medicare Part B: After calendar deductible 20% of our allowance

Benefit Description: Specialist

High Option You pay without Medicare: After calendar deductible 20% of our allowance
High Option You pay with Medicare Part B: After calendar deductible 20% of our allowance

Benefit Description: Inpatient Hospital

High Option You pay without Medicare: After calendar deductible 20% of our allowance
High Option You pay with Medicare Part B: After calendar deductible 20% of our allowance

Benefit Description: Outpatient Hospital

High Option You pay without Medicare: After calendar deductible 20% of our allowance
High Option You pay with Medicare Part B: After calendar deductible 20% of our allowance

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

Benefit Description: Incentives offered

High Option You pay without Medicare: N/A
High Option You pay with Medicare Part B: NA

You can find more information about how our plan coordinates benefits with Medicare by calling 855-580-1200 or visit our website at www.anthem.com.

- **Tell us about your Medicare coverage**

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

- **Medicare Advantage (Part C)**

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

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

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

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

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers).

However, we will not waive any of our copayments, coinsurance, or deductible. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

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

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

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

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

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

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

Section 10. Definitions of Terms We Use in this Brochure

Calendar year

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

Catastrophic limit

See Section 4.

Clinical Trials Cost Categories

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

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

Coinsurance

See Section 4.

Copayment

See Section 4.

Cost-sharing

See Section 4.

Covered services

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

Custodial care

Any type of care, including room and board, that (a) does not require the skills of professional or technical workers; (b) is not given to you or supervised by such workers or does not meet the rules for post-Hospital Skilled Nursing Facility care; and (c) is given when you have already reached the greatest level of physical or mental health and are not likely to improve further. Custodial Care includes any type of care meant to help you with activities of daily living that does not require the skill of trained medical or paramedical workers. Examples of Custodial Care include: help in walking, getting in and out of bed, bathing, dressing, eating, or using the toilet, changing dressings of non-infected wounds, after surgery or chronic conditions, supervising medicine that you can take yourself, residential care and adult day care, protective and supportive care, including education, or rest and convalescent care.

Care can be Custodial even if it is recommended by a professional or performed in a Facility, such as a Hospital or Skilled Nursing Facility, or at home.

Calendar year deductible

See Section 4.

Experimental or investigational services

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.

- This criterion will be satisfied if the use of the drug is recognized for treatment of the indication or application in any of the following resources:
  - the following three standard reference compendia defined below:
    - American Hospital Formulary Service - Drug Information
    - National Comprehensive Cancer Network's Drugs & Biologics Compendium
    - Elsevier Gold Standard's Clinical Pharmacology
  - in substantially accepted peer-reviewed medical literature. Peer-reviewed medical literature means a scientific study published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts. This study must appear in a journal that has been determined by the International Committee of Medical Journal Editors to have met the Uniform Requirements for Manuscripts submitted to biomedical journals. Peer-reviewed medical literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier; or
- In the case where the drug is being used for the treatment of a specific type of cancer, this criterion will be satisfied if the use of the drug is recognized as safe and effective for treatment of the specific type of cancer in any of the standard reference compendia.

  Despite the above two exceptions, this criterion will not be satisfied if the FDA has determined that use of the drug is not recommended for the treatment of the specific indication for which it is prescribed.

2. There must be enough information in the peer-reviewed medical and scientific literature to let us judge the safety and efficacy.
3. The available scientific evidence must show a good effect on health outcomes outside a research setting.
4. The service or supply must be as safe and effective outside a research setting as current diagnostic or therapeutic options.

   New technologies are evaluated against these criteria to determine if services should be included as a covered benefit or considered experimental/investigative.

Health Reimbursement Arrangement (HRA)

An HRA combines a Fund with a deductible-based medical plan with coinsurance limits. The HRA Fund pays first. Once you exhaust your HRA Fund, Traditional medical coverage begins after you satisfy your deductible. Your HRA Fund counts toward your deductible.

Health Savings Account (HSA)

An HSA is a special, tax-advantaged account where money goes in tax-free, earns interest tax-free and is not taxed when it is withdrawn to pay for qualified medical services.

Healthcare professional

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

Medical necessity

For a service to be medically necessary the service must:

- be required to identify or treat an illness, injury, or pregnancy-related condition;
- be consistent with the symptoms or diagnosis and treatment of your condition;
- be in accordance with standards of generally accepted medical practice; and
- be the most suitable supply or level of service that can safely treat the condition and not be for the convenience of the patient, patient's family, or the provider.

Plan allowance

Our Plan allowance is the amount we use to determine our payment and your coinsurance for covered services.

	You should also see Important Notice About Surprise Billing – Know Your Rights in Section 4 that describes your protections against surprise billing under the No Surprises Act.
Post-service claims	Any claims that are not pre-service claims. In other words, post-service claims are those claims were treatment has been performed and the claims have been sent to us in order to apply for benefits.
Pre-service claims	Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.
Reimbursement	A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.
Rollover	Any unused, remaining balance in your HDHP HSA/HRA at the end of the calendar year may be rolled over to subsequent years.
Subrogation	A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.
Urgent care claims	A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts: • Waiting could seriously jeopardize your life or health; • Waiting could seriously jeopardize your ability to regain maximum function; or • In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Urgent care claims usually involve Pre-service claims and not Post-service claims. We will determine whether or not a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at 855-580-1200. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.
Us/We	Us and we refer to HealthKeepers.
You	You refers to the enrollee and each covered family member.

Index

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

Notes

Notes

Summary of Benefits for HealthKeepers HDHP - 2022

Do not rely on this chart alone. This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this FEHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.anthem.com. If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

In 2022 for each month you are eligible for the Health Savings Account (HSA [Plan] will deposit $$75 per month for Self Only enrollment, $150 for Self Plus One enrollment or $150 per month for Self and Family enrollment to your HSA. For the HSA you may use your HSA or pay out of pocket to satisfy your calendar year deductible of $1,500 for Self Only, $3,000 for Self Plus One and $3,000 for Self and Family. Once you satisfy your calendar year deductible, Traditional medical coverage begins.

For the Health Reimbursement Arrangement (HRA), your health charges are applied to your annual HRA Fund of $900 for Self Only, $1,800 for Self Plus One, and $1,800 for Self and Family. Once your HRA is exhausted, you must satisfy your calendar year deductible. Once your calendar year deductible is satisfied, Traditional medical coverage begins.

HDHP Benefits	You Pay	Page
Network medical preventive care	Nothing at a network provider (calendar year deductible does not apply)	37
Medical services provided by physicians:	Network: 20% of our allowance Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount	40
Services provided by a hospital: Inpatient	Network: 20% of our allowance Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount	56
Services provided by a hospital: Outpatient	Network: 20% of our allowance Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount	57
Emergency benefits: In-area and Out-of-area	20% of our allowance	61
Mental health and substance use disorder treatment:	Network: 20% of our allowance Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount	63
Prescription drugs: After your deductible has been satisfied, your copayment will apply. • Retail pharmacy	Network: Level 1 up to a 30-day supply Tier 1 - $10 Tier 2 - $40 Tier 3 - $70 Level 2 up to a 30-day supply Tier 1 - $20 Tier 2 - $50 Tier 3 - $80 Tier 4 - 25% of our allowance up to a $300 maximum	66

	Out-of-network (retail pharmacy only): 30% of our allowance after calendar year deductible	
Prescription drugs: After your deductible has been satisfied, your copayment will apply. • Mail order (available network only)	Mail order and online up to a 90-day supply Tier 1 - $25 Tier 2 - $100 Tier 3 - $175	66
Dental care: Accidental injury only	Network: 20% of our allowance Out-of-network: 40% of our allowance and any difference between our allowance and the billed amount	69
Vision care: Adult - one exam per calendar year through Blue View Vision	Network: Nothing Out-of-network: Reimbursed up to $30	44
Vision care: Pediatric - one exam per calendar year through Blue View Vision	Network: Nothing Out-of-network: Nothing up to the maximum allowed amount	44
Special features: Flexible benefits option, 24 hour nurse line, Reciprocity and Centers of excellence.		70
Protection against catastrophic costs (out-of-pocket maximum)**:**	Network: Nothing after $5,000/Self Only enrollment, $10,000/Self Plus One enrollment or $10,000/Self and Family enrollment per year. Out-of-network: Nothing after $7,000/Self Only enrollment, $14,000/Self Plus One enrollment or $14,000/Self and Family enrollment per year.	23

2022 Rate Information for HealthKeepers HDHP

To compare your FEHB health plan options please go towww.opm.gov/fehbcompare**.**

To review premium rates for all FEHB health plan options please go to www.opm.gov/FEHBpremiums or www.opm.gov/Tribalpremium.

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

Type of Enrollment	Enrollment Code	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share
Virginia					
HDHP Option Self Only	9V1	$185.96	$61.98	$402.90	$134.30
HDHP Option Self Plus One	9V3	$423.03	$141.01	$916.57	$305.52
HDHP Option Self and Family	9V2	$452.79	$150.93	$981.05	$327.01