



KeyCare HSA[®]

KeyCare HealthSmartSM

KeyCare HealthSmartSM
with Enhanced Prescription Drug Benefit

Anthem Individual KeyCare Plans

**A Benefit Guide to help you find affordable
health care coverage that works for you.**

Welcome to Anthem Blue Cross and Blue Shield

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Now more than ever, Virginians need protection against the rising cost of medical care, particularly those who don't have access to employer-sponsored health benefits. Millions of Americans don't have health insurance through their work. Perhaps they are self-employed. Between jobs. Their employer doesn't offer health insurance. Whatever the reason, they need innovative, affordable solutions for individuals, so they can protect themselves and their families.

Anthem Blue Cross and Blue Shield is pleased to offer three high deductible Individual KeyCare health plans for individuals: Anthem KeyCare HSA, KeyCare HealthSmart, and KeyCare HealthSmart with Enhanced Drug Benefit.



Interested in a Health Savings Account (HSA)?
Look for the piggy bank to see plans that are designed to be compatible with an HSA!

What is a KeyCare Plan?

The term KeyCare refers to Anthem Blue Cross and Blue Shield's KeyCare PPO (Preferred Provider Organization) network. KeyCare plans offer you the cost-savings of a PPO network. For more information about the KeyCare network, including what happens when you do not use a network provider, see page 4.

Anthem Individual KeyCare Plans

Choose the plan that is right for you.

Each Anthem Individual KeyCare plan is designed with different health care needs and budgets in mind. And within each plan, you have a choice of deductibles, to help you find a premium that works for you.

Take care of your health!

All Individual KeyCare plans offer benefits for important routine wellness care, or preventive care services. We hope our members use them. Preventive care, along with other healthy lifestyle choices, helps keep the cost of health care and health insurance down for everyone.

KeyCare HSA



If eligible, members can take advantage of potential tax savings and flexibility by establishing a Health Savings Account with this plan*.

Offers:

- Lowest premium plan with solid protection
- Preventive Care and Immunizations for children (from birth through age 6) included, before meeting the deductible
- A simple cost-sharing design: All covered out-of-pocket expenses apply to your expense limit. And, your expense limit helps cap your overall expenses. In fact, with the highest deductibles, your expense limit equals the deductible. So think of it this way: you enjoy premium savings with the highest deductibles. And, once you meet those amounts, your covered services (received in-network) are covered at 100% for the rest of the year.

Consider:

- High deductibles require more planning and cost-sharing on your part
- One deductible applies to all covered persons
- All covered services, except preventive care and immunizations for children are covered after the deductible is met
- Prescription drugs are covered after the policy deductible
- Additional \$150 limitation for routine immunizations, lab work and x-rays

* If eligible, you may be able to deduct HSA contributions from your gross income on your federal tax return, even if you do not itemize deductions. Many states allow the deduction from state income taxes. Please consult your tax advisor to determine the best strategy for you.

KeyCare HealthSmart



Innovative. Compatible with a Health Savings Account (HSA). Provides affordable protection against higher medical expenses, with first dollar coverage for important routine wellness care.

Offers:

- Affordable premium with unlimited routine wellness doctor visits at predictable co-payment and routine screenings covered before the deductible
- No dollar limit for routine immunizations, lab work and x-rays
- A simple cost-sharing design: All covered out-of-pocket expenses apply to your expense limit. And, your expense limit helps cap your overall expenses. In fact, with the highest deductibles, your expense limit equals the deductible. So think of it this way: you enjoy premium savings with the highest deductibles. And, once you meet those amounts, your covered services (received in-network) are covered at 100% for the rest of the year.

- Preventive Care and Immunizations for children included, before meeting the policy deductible
- Optional supplemental accident coverage, which covers 100% of the allowable charges, up to an annual \$750 per person for your family members that may have accidents

Consider:

- High deductibles require more planning and cost-sharing on your part
- One deductible applies to all covered persons
- Prescription drugs are covered after the policy deductible

KeyCare HealthSmart with Enhanced Prescription Drug Benefit

Offers health benefits similar to KeyCare HealthSmart, with prescription drug coverage paid before meeting the policy deductible. The deductible is the amount you pay towards covered health care services each calendar year before receiving certain benefits.

Consider:

- Cannot be paired with a Health Savings Account
- Prescription drug expenses do not apply to the policy's out-of-pocket expense limit

The Basics

The first section of your KeyCare Plan Benefit Summary is called “The Basics”. This section describes how Anthem will share the cost of your health care with you.

The cost of health insurance depends on many things, including the level of cost sharing between you and the health insurer. When you think about cost sharing, consider how you plan to use your benefits, and how much expense you could handle if you had unexpected medical bills. Remember, other than your Lifetime Maximum Benefit, cost-sharing is measured each calendar year.

Here are some important cost-sharing terms:

Coinsurance

The percentage of the allowable charge you pay for covered services. Your level of coinsurance depends on the deductible you choose. With larger deductibles, you pay more out of your pocket before your benefits begin, so we set your coinsurance at 0%.

Copayment, or Copay

The flat, fixed fee you pay for certain covered services, such as routine doctor visits in the HealthSmart plans.

Deductible

The amount you or your family pay towards covered health care services each calendar year before receiving benefits. Choosing a higher deductible and out-of-pocket maximum will lower your premium.

One deductible applies to all covered persons.

Lifetime Maximum Benefit

The maximum amount we will cover during the lifetime of the policy for each covered person.

Out-of-Pocket Expense Limit, or Expense Limit

This is the total amount you are responsible for paying out-of your pocket for covered services. Your annual out-of-pocket expense limit helps protect you from high dollar medical expenses by limiting what you pay for yearly covered health care expenses. Your out-of-pocket expense limit helps control your policy expenses: your coinsurance, copayments and deductible.

**A Quick Look at Cost Sharing:
What's important to you?**

	KeyCare HSA	KeyCare HealthSmart	KeyCare HealthSmart with Enhanced Prescription Drug Benefit
Lower premiums? Higher deductible options	Yes.	Yes.	Yes.
Family deductible? Shared deductible for all family members?	Yes.	Yes.	Yes.
A plan you can pair with a Health Savings Account?	Yes.	Yes.	No.
A simple design? Once you pay a certain amount for the year, your policy pays all other covered expenses.	Yes.	Yes.	Yes, except prescription drugs.

The Benefits

Anthem KeyCare Providers. Helping you stay healthy. Helping you save money.

With Anthem Individual KeyCare Plans, you save money by visiting doctors and hospitals in the Anthem KeyCare PPO (Preferred Provider Organization) network.

A big part of KeyCare network savings is Anthem's **allowable charge**, or the allowance Anthem will pay for covered services. Our allowable charge is often less than the provider's normal charge. KeyCare providers (hospitals, doctors, and other medical providers in the KeyCare PPO network) agree to accept Anthem's allowable charge as payment in full.

How does this save you money? With a KeyCare provider, any coinsurance amount you owe is a percentage of our allowable charge – which reduces your share of the cost. Haven't met your deductible yet? With a KeyCare provider, you are only responsible for paying Anthem's allowable charge for covered services – **so you save money even before your benefits begin.**

Flexibility

With Anthem KeyCare PPO plans, you can visit providers outside the KeyCare network and still have benefits. However, your share of the cost for covered services will increase.

Outside the network, you will be responsible for meeting:

- a separate deductible and out-of-pocket expense limit,
- a higher coinsurance amount, and
- any difference between Anthem's allowable charge and the provider's actual charge.

In addition, providers outside the KeyCare PPO network may not file your claims for you.

In most cases, KeyCare providers will file your claims for you, saving you time, hassle, and postage costs¹.

¹ Automatic claims filing is a value-added service and is not part of nor guaranteed by the policy, and can be modified or discontinued at our discretion.

Hospital Inpatient and Outpatient Care, and Emergency Care

Benefits work the same for all the plans. You pay a coinsurance amount after meeting the deductible.

A Large Network

Anthem's KeyCare PPO network is one of the largest Preferred Provider Organizations in Virginia. Over 85% of Virginia doctors and hospitals are in the KeyCare network¹ – so chances are your doctor is already a KeyCare provider. You can find a list of Anthem KeyCare PPO providers on anthem.com.

¹ Anthem Blue Cross and Blue Shield Provider Network Report, April 2006.

Emergency Care

If you need emergency care, you should go to the closest doctor or hospital available. If it is a true emergency, you will receive in-network benefits even if the provider is not in the KeyCare network. Anthem considers **Emergency Care** to be services and supplies for emergency treatment of traumatic bodily injuries resulting from an accident or a sudden onset of a life-threatening medical condition. Emergencies include cardiac arrest, appendicitis, heat stroke, or other severe medical conditions.

Routine Wellness Doctor Visits

Coverage for routine doctor visits varies between plans. With KeyCare HealthSmart and KeyCare HealthSmart with Enhanced Drug Benefit, you pay a set amount before meeting the deductible. KeyCare HSA requires a coinsurance amount after meeting the deductible.

What's important to you?

	KeyCare HSA	KeyCare HealthSmart	KeyCare HealthSmart with Enhanced Prescription Drug Benefit
Prescription drugs before deductible.	No.	No.	Yes.
Doctor visits before deductible?	No.	Routine Wellness visits only.	Routine Wellness visits only.
Routine wellness visits covered before deductible	Only for children from birth through age 6.	Yes.	Yes.
Predictable Copayment?	No.	For routine office visits only.	For routine office visits only.

Routine Wellness

For routine care, you share the cost for the following types of services:

The office visit

Routine wellness doctor office visits are covered starting at age 7.

The screenings

Screenings include:

- (1) simple procedures, such as lab work, x-rays and immunizations, and
- (2) more complicated, costly procedures, such as cancer screenings.

Preventive Care Services Include:

Service/Screening	Age	Frequency
Pap Smear	Any age	1 per year
Mammography Prostate (PSA)	35 & older 50 & older (40 - 49 if high risk)	
Colonoscopy	As recommended by the American College of Gastroenterology & the American Cancer Society	

What's important to you? Adult Preventive Care

	KeyCare HSA	KeyCare HealthSmart	KeyCare HealthSmart with Enhanced Prescription Drug Benefit
Routine doctor visits, per person, per year	Two visits per person.	Unlimited for routine care.	Unlimited for routine care.
Covered before deductible?	No.	Yes.	Yes.
Routine Screenings covered before the deductible?	No.	Yes.	Yes.
Extra \$150 for routine lab work, x-rays & immunizations	Yes.	Coverage is unlimited.	Coverage is unlimited.

Preventive Care & Immunizations for Children

All three KeyCare plans include preventive care benefits for children from birth through age six. These benefits are easy to use – services are covered at 100% of the allowable charge in or out-of-network. No deductible, no copayment or coinsurance. A specific list of these covered services can be found on anthem.com.

They include:

- Office visits
- Vision and hearing screenings
- Lab tests
- Immunizations

Prescription Drugs

The cost of prescription drugs can be staggering. In fact, prescription drug costs are one of the leading drivers of rising health care costs. Helping control those costs is the key to providing affordable health care and health insurance for everyone.

KeyCare HealthSmart and KeyCare HSA cover up to \$5,000 per person in yearly prescription drug benefits, after you meet your policy deductible.

KeyCare HealthSmart with the Enhanced Prescription Drug Benefit provides prescription drug benefits before the deductible. Prescription drug benefits are divided into two categories, or tiers.

With non-specialty, or Tier 1 drugs, you pay the greater of a \$15 copayment or 40% coinsurance, up to an annual maximum of \$5,000 per person.

With specialty drugs, or Tier 2 drugs, you pay 40% coinsurance, up to a \$500 out-of-pocket limit per prescription. Specialty drugs can be very expensive, so for added protection, this plan offers an annual \$10,000 out-of-pocket limit per person for specialty drugs.

What are Specialty Drugs?

Specialty drugs are high-cost, scientifically engineered drugs. They are usually injected or infused, and require special storage and handling that make them difficult for a typical pharmacy to dispense. Certain specialty drugs are only available through Anthem's Specialty Pharmacy Network, PrecisionRx Specialty Solutions. If you enroll in KeyCare HealthSmart with Enhanced Drug Benefit, you'll receive more information about this in your member kit.

Keycare HSA and KeyCare HealthSmart - Prescription Drug Filing Card

Your Anthem prescription drug filing card can be used at any participating pharmacy. You will be responsible for paying Anthem's allowable charge for the drug (usually less than the retail price) at the time of purchase. Participating pharmacies will file the claim for you, and once you have met your policy deductible, you will receive our reimbursement by mail. Our reimbursement will be for Anthem's allowable charge, less any applicable coinsurance amount, up to the \$5,000 annual maximum amount per person for prescription drug expenses.

When you visit a non-participating pharmacy, your benefits work the same in terms of deductible, coinsurance, our reimbursement, and the \$5,000 annual maximum. However, non-participating pharmacies may not file your claims for you, and may charge you for the full price of the drug (not our allowable charge) at the time of purchase.

Benefits available at an additional cost

Why pay extra for benefits you won't use? We offer optional coverage that you can add to your plan for an additional cost, so you can find coverage that best fits your life today, and tomorrow.

Maternity

If you're hoping to add to your family in the future, you may want to think about adding maternity coverage now. Conception must occur at least six months after the effective date of this coverage, even if you qualify for credit toward your base policy's 12 month pre-existing waiting period (see page 12 for the definitions of pre-existing condition and waiting period). Pregnant women who are HIPAA (Health Insurance Portability and Accountability Act) "eligible individuals" may not have to wait six months. Your enclosed Anthem application defines HIPAA-eligible individuals. Your Anthem sales representative will have more information.

Note: Maternity coverage cannot be added to a policy insuring one male without a female spouse or female domestic partner on the policy, or for female applicants under age 18 unless they are emancipated minors.

The maternity coverage helps pay for:

- childbirth,
- prenatal and postnatal care,
- use of delivery room,
- hospital bed and board for mother,
- routine nursery care,
- routine newborn circumcision,
- cesarean section deliveries and
- diagnostic x-rays and lab charges.

Supplemental Accident Coverage

All KeyCare plans provide emergency care benefits, but the unexpected costs of an accident can still add up. You can purchase Supplemental Accident Coverage to help you with these costs. In order to make the most of your KeyCare benefits, you'll still need to visit a KeyCare network provider. If you visit a provider outside the KeyCare network, your share of the costs for covered services may increase. Supplemental Accident Coverage benefits are available before any deductible.

With KeyCare HSA:

- Anthem pays 100% of the allowable charge, up to \$500 per accident.

With KeyCare HealthSmart and KeyCare HealthSmart with Enhanced Prescription Drug Benefit:

- Anthem pays 100% of the allowable charge, up to a total of \$750 per person, per year.

What if I want to add (or delete) optional coverage later?

Generally, you can add or delete optional coverage on your policy's anniversary date, or when you experience a major life change, including marriage, divorce, legal separation, birth of a child, adoption, death, adding or deleting a dependent, or entering the military.

Dental Coverage

Offered with all three KeyCare plans: Dental coverage provides preventive, restorative and complex care.

Dental coverage is important to your overall health and well-being.

Regular dental check-ups can serve as an early warning for health-related issues. In fact, gum and tooth disease have been linked to a number of major health conditions like heart disease, stroke, respiratory disease

and diabetes. Who knew seeing a dentist may help save your life? Protect your smile – and your health – with dental coverage.

You'll save more on the cost of your dental care when you visit a participating network dentist. Going out of the network means you'll be responsible for more of the cost. To find a network dentist in your area visit us at anthem.com.

You will save more on the cost of your dental care when you visit a KeyCare network dentist. Going out of the network means you'll be responsible for more of the cost and you will have to meet a separate, higher deductible for restorative and complex care. To find a network dentist in your area, visit us at anthem.com.

PREVENTIVE CARE

COVERED SERVICES	WAITING PERIOD	COINSURANCE		DEDUCTIBLE		MAXIMUM COVERED PER YEAR
		IN NETWORK	OUT-OF NETWORK	IN NETWORK	OUT-OF NETWORK	
Diagnostic (2 oral exams)	None	0%	50%	None	None	\$1,000 per covered person for preventive, restorative and complex care.
X-Rays (1 set of bitewings per year. 1 full mouth series every 3 years for covered persons age 5 and over)						
Preventive (includes cleanings, topical fluoride treatments for children under 16, space maintainers for children under 12)						

RESTORATIVE AND COMPLEX CARE

COVERED SERVICES	WAITING PERIOD	COINSURANCE		DEDUCTIBLE		MAXIMUM COVERED PER YEAR
		IN NETWORK	OUT-OF NETWORK	IN NETWORK	OUT-OF NETWORK	
Restorative Services (fillings)	6 months	50%	50%	\$50/ individual up to \$150/ family	\$100/ individual up to \$300/ family	\$1,000 per covered person for preventive, restorative and complex care.
Simple Extractions						
Anesthesia (emergency treatment of dental pain for minor procedures, general anesthesia with oral surgery)						
Oral Surgery (includes root removal, treatment of abscess)	18 months	50%	50%	\$50/ individual up to \$150/ family	\$100/ individual up to \$300/ family	
Prosthodontic Services (includes onlays, crowns, dentures)						
Endodontic Services (root canals)						
Periodontal Services (includes periodontal cleaning, scaling, and root planing)						

Policy Terms

The following are provisions to our policies, which outline specific requirements and procedures about our plans. However, keep in mind that this brochure is not your official policy. The policy you receive when you enroll in a plan will be a legal document that overrides any other descriptions of your coverage. Be sure to read it.

Eligibility

Anthem Blue Cross and Blue Shield Individual Coverage is available only to those who:

- reside in the Anthem Blue Cross and Blue Shield service area; reside in the KeyCare service area;*
- qualify medically and meet certain life-style criteria;
- are under age 65;
- are not entitled to Medicare benefits;
- do not currently have individual protection that provides similar benefits, unless Anthem's individual coverage will replace existing coverage; and
- are not on active duty with any branch of the Armed Services.

Eligible children must also be:

- unmarried; and
- under age 23

To be eligible for coverage as a domestic partner, you:

- must have been living together six or more months and plan to continue living together;
- are financially inter-dependent;
- are at least 18 years old; and
- are not married to anyone else and are not related by blood in a way that would prohibit marriage.

You, your spouse or domestic partner and dependent children are not eligible for this coverage if any person to be covered has been enrolled in an Anthem group plan within the last 64 days of the effective date of this individual plan. If you are a retiree and your employer does not contribute to you or your dependent's coverage, you, your spouse or domestic partner and dependents are eligible to apply.

Renewability

Your coverage is automatically renewed as long as:

- premiums are paid according to the terms of your policy;
- the insured lives, works, or resides in our service area; and
- there are no fraudulent or material misrepresentations on your application or under the terms of your coverage.

We can refuse to renew your policy if all policies of the same form number are also not renewed. Any such action will be in accordance with applicable state and Federal laws.

Premium

We determine premiums based on such factors as age, sex, type and level of benefits, membership type, health, lifestyle and area of residence. These premiums are set by class. You will never be singled out for a premium change. Your premium may be adjusted periodically. We will give you prior written notice of any premium change we initiate.

Employer payment of premiums

The policies described in this brochure are individual health insurance policies, and, as such, cannot be used as employer-provided health care benefit plans. No employer of any covered person under these policies may contribute to premiums directly or indirectly, including wage adjustments. As it pertains to this section, an employer does not include a trade or business wholly owned by an individual or individual and spouse or domestic partner that has no other employees or that does not offer health benefits to any other employees. Also, as it pertains to this provision, a church may purchase an individual policy if only purchasing it for one employee.

Termination

Coverage ends for all persons insured under the policy if the insured dies. A covered person or guardian of a covered person must contact us to arrange for continued coverage in this instance.

Covered dependent coverage ends under these circumstances:

- for a covered spouse upon divorce from the covered person in whose name the policy was obtained;
- when a covered dependent begins active duty with the Armed Services;
- death of the dependent; or
- at the insured's request.

If a covered child is incapable of earning a living because of a mental or physical handicap that began before age 23, we will continue to cover the child as long as the policy is in force.

Cancelling your policy

If you wish to cancel your Anthem policy, you must call or notify us in writing. Any premium paid beyond your cancellation date will be refunded to you promptly after the cancellation.

Limited Benefit Policy

Our KeyCare plans are "limited benefit policies," meaning that there are times when you may be responsible for more than the 25% maximum coinsurance set by insurance regulations for major medical coverage. This happens only when your copayment or coinsurance is greater than the 25% coinsurance, or when you use an out-of-network provider.

* If you are an "Eligible Individual," as defined on the application, then coverage is available to you if you live, work or reside in our service area, (or the KeyCare service area if applying for a KeyCare plan).

What's Not Covered

Remember, all health care plans are different. To choose the plan that best meets your needs, it's important to understand not only what it covers, but what it does not cover.

EXCLUSIONS:

Our KeyCare HSA, KeyCare HealthSmart and KeyCare HealthSmart with Enhanced Prescription Drug Benefit policies do not cover:

Pre-existing conditions

A pre-existing condition is any medical condition you had in the 12 months before your "effective date," or the date you are officially covered by the new policy. During the first 12 months after your effective date, the plans in this brochure do not cover prescription drugs prescribed for a pre-existing condition, services for, or complications resulting from, a pre-existing condition.

The waiting period for pre-existing conditions may be shorter, or waived, if you're transferring your coverage from a qualifying health plan.

Preventive care services

The policy only covers preventive care specified in the policy. It does not cover routine physical examinations, routine laboratory tests or routine x-rays that exceed what is specifically provided for in the policy.

Services not medically necessary

Services or care that are not medically necessary as determined by us, in our sole discretion.

We cover only medically necessary services in order to keep everyone's premiums down and to make sure services are provided in a safe, approved setting. Our licensed medical staff uses careful guidelines based on accepted medical practice to determine whether a service is medically necessary. These guidelines apply to everyone. You can find out whether a particular service or procedure is medically necessary and covered before you receive it, by calling us when you're considering treatment options with your physician. We'll work with you to find the safest and most effective treatment.

Services that are deemed experimental or investigative

Services that we deem, in our sole discretion, to be experimental/investigative, except in certain limited circumstances as listed in the policy.

The Blue Cross and Blue Shield Association has a committee of medical professionals that reviews new medical treatments, examines the current scientific medical literature and recommends coverage for those treatments that are shown to be safe and effective. They do not recommend new treatments that are still experimental or under investigation. Our medical staff follows the committee's recommendations and guidelines to decide whether a new treatment can be covered by the policy.

Organ and tissue transplants, transfusions

Certain organ or tissue transplants that are considered experimental/investigative or not medically necessary.

Maternity and family planning services

Pregnancy related conditions, except complications of pregnancy as specifically provided for in the policy. We only cover complications of a pregnancy that began after your policy started and include conditions that would be considered life-threatening to the mother.

We do not cover family planning services including services and prescription drugs prescribed for or related to artificial insemination or in vitro fertilization or any other types of artificial or surgical means of conception. We also do not cover reversals of sterilization which resulted from a previous elective sterilization.

Dental services

Dental care, except as specifically provided for in the policy.

Hearing services

Implantable or removable hearing aids, including exams for prescribing or fitting hearing aids, regardless of the cause of hearing loss, with the exception of cochlear implants.

Vision services

Services for, or related to, procedures performed on the cornea to improve vision, in the absence of trauma or previous therapeutic process. Medical or surgical procedures to correct nearsightedness, far-sightedness, and/or astigmatism.

Foot care

Services for palliative or cosmetic foot care.

Cosmetic services

All medical, surgical, and mental health services for or related to cosmetic surgery and/or cosmetic procedures, including any medical, surgical, and mental health services to correct complications of a person's cosmetic procedure. Body piercing and cosmetic tattooing are considered cosmetic procedures. "Cosmetic surgery," however, does not mean reconstructive surgery incidental to or following surgery caused by trauma, infection, or disease of the involved part. We determine, in our sole discretion, whether surgery is cosmetic or is clearly essential to the physical health of the patient.

Certain types of therapies

Therapy primarily for vocational rehabilitation; certain drugs and therapeutic devices, including over-the-counter drugs and exercise equipment; outpatient services for marital counseling, coma-stimulation activities, educational, vocational, and recreational therapy, manual medical interventions for illnesses or injuries other than musculoskeletal illnesses or injuries.

What's Not Covered

Certain facility and home care

Services for rest cures, residential care or custodial care. Your coverage does not include benefits for care from a residential treatment center or non-skilled, subacute settings, except to the extent such settings qualify as substance abuse treatment facility licensed to provide a continuous, structured, 24 hour-a-day program of drug or alcohol treatment and rehabilitation including 24 hour-a-day nursing care.

Transportation services

Travel or transportation, except by professional ambulance services as described in the policy.

Services covered under government programs or employee benefits

Services covered under Federal or state programs (except Medicaid); services for injuries or sickness resulting from activities for wage or profit when 1) your employer makes payment to you because of your condition; 2) your employer is required by law to provide benefits to you; or 3) you could have received benefits for your condition if you had complied with the relevant law.

Services related to the military, war or civil disobedience

Services for injuries or sickness sustained while serving in any branch of the armed forces or resulting from acts of war.

Services for injuries or sickness resulting from participation in a felony, riot or any other act of civil disobedience.

Any loss resulting from the covered person being under the influence of alcohol, intoxicants, illegal substances, or any prescription drug (unless the prescription drug is taken on the specific advice of a physician in a manner consistent with the advice).

Services provided by family or co-workers

Services performed by your immediate family or by you; services rendered by a provider to a co-worker for which no charge is normally made in the absence of insurance.

Separate charges

Separate charges for services by health care professionals employed by a covered facility which makes those services available.

Prescription drugs

We do not cover:

- prescription drugs prescribed for pre-existing conditions during the first 12 months of coverage;
- over-the-counter drugs;
- charges to administer prescription drugs or insulin, except as stated in the policy;
- prescription refills that exceed the number of refills specified by the provider;
- a prescription that is dispensed more than one year after the order of a physician;

- drugs that are consumed or administered at the place where they are dispensed, except as stated in the policy;
- prescription drugs prescribed for weight loss or as stop-smoking aids;
- prescription drugs prescribed primarily for cosmetic purposes;
- prescription drugs dispensed by anyone other than a pharmacy with the exception of a physician dispensing a one-time dosage of an oral medication either at the physician's office or in a covered outpatient setting in order to treat an acute situation, and;
- prescription drugs not approved by the FDA.

Other non-covered services

- Services for which a charge is not normally made.
- Amounts above the allowable charge for a service.
- Services or supplies not prescribed, performed or directed by a provider licensed to do so.
- Services if they are for dates of service before the effective date or after a covered person's coverage ends.
- Telephone consultations, charges for not keeping appointments, or charges for completing forms or copying medical records.
- Services not specifically listed or described in this policy as covered services.
- Services to treat sexual dysfunction, including services for or related to sex transformation, when the dysfunction is not related to organic disease. This includes related medical services and mental health services.
- Complications of non-covered services — these services would include treatment of all medical, mental health and surgical services related to the complication.
- Services or supplies ordered by a physician whose services are not covered under the policy.
- Self-help, training, and self-help administered services.
- Manual medical interventions for illnesses or injuries other than musculoskeletal illnesses or injuries.

Out-of-pocket expense limit exclusions

The following items never count toward your out-of-pocket expense limit for KeyCare HSA and KeyCare HealthSmart:

- amounts exceeding the allowable charge and expenses for services not covered under the policy.

The following items never count toward your out-of-pocket expense limit for KeyCare HealthSmart with Enhanced Drug Benefit:

- amounts paid for prescription drugs, including specialty drugs and insulin;
- amounts exceeding the allowable charge, and;
- expenses for services not covered under the policy.

What's Not Covered

Optional Coverage exclusions

Adding optional coverage to your policy changes certain exclusions in your policy related specifically to services for dental care, pregnancy, accidents or preventive care and immunizations for children. But other limitations and exclusions continue to apply.

Dental Coverage exclusions

This Coverage does not cover:

- services not listed or described in your policy or in the optional coverage endorsement;
- dental services that are covered under any other dental benefits plan under which a covered person is enrolled;
- dental services with respect to congenital or developmental malformation or primarily for cosmetic purposes except as specified in the optional coverage endorsement;
- upgrading of serviceable dentistry;
- services rendered prior to the optional coverage effective date, and services rendered on or after the optional coverage effective date that are directly related to services received before the optional coverage effective date;
- services rendered after the date of termination of the dental coverage;
- dental pit/fissure sealants on other than first and second permanent molars;
- diagnostic photographs;
- dietary instruction or other counseling;
- silicate restorations;
- sedative fillings; root canal therapy on other than permanent teeth; pulp capping (direct or indirect);
- sedative fillings; root canal therapy on other than permanent teeth; pulp capping (direct or indirect);
- separate charges for pulp vitality tests and bases and liners under restorations;
- therapeutic pulpotomy on other than primary teeth;
- guided tissue regeneration, including flap entry or re-entry and closure;
- gingival curettage;
- separate charges for irrigation or re-evaluation following periodontal therapy;
- periodontal splinting and occlusal adjustments for periodontal purposes;
- controlled release of medications to tooth crevicular tissues for periodontal purposes;
- repositioning appliances or restorations necessary to increase vertical dimensions or restore or correct the occlusion;
- services rendered for purposes other than to eliminate oral disease and/or replace covered missing teeth (mouth rehabilitation);
- gold foil restorations;
- inlays;
- temporary dentures or temporary crowns, or duplicate dentures;
- services to replace teeth that were lost or extracted prior to the rider's effective date;
- services to replace non-functioning teeth;
- fixed bridges when done in conjunction with a removable appliance in the same arch;
- precision attachments for dental appliances;

- tissue conditioning;
- prefabricated resin crowns;
- dental implants and associated services in conjunction with implants;
- consultations (including telephone consultations), charges for failure to keep a scheduled visit, charges for completion of a claim form, or charges for providing information in connection with a claim;
- occlusal guards and athletic mouth guards;
- bleaching or whitening of discolored teeth;
- behavior management or hypnosis;
- therapeutic injections;
- orthodontic services;
- separate charges for infection control procedures and procedures to comply with Occupational Safety and Health Administration (OSHA) requirements;
- analgesics (nitrous oxide);
- occlusal analysis;
- tooth desensitizing treatments; and
- When coverage is available for the following services, these services require the performance of diagnostic x-rays six months prior to the earlier of (1) the request for predetermination of such services or (2) the date the services were rendered:
 - more than one (1) crown;
 - fixed prosthetic devices; or
 - surgical extraction of impacted teeth.

If diagnostic x-rays are not performed as specified above, the services listed above are not covered.

Maternity coverage exclusions

Maternity coverage covers pregnancies that begin at least six months after the rider becomes effective. Maternity and pregnancy-related benefits are only available to the female insured or the female covered spouse/ domestic partner who is at least 18 years of age or an emancipated minor. It does not cover maternity services for dependent children or a male spouse. The six month time period may not apply to you if you meet certain eligibility requirements. Call your Anthem Sales Representative for more details.

Supplemental accident coverage exclusions

The supplemental accident coverage covers ambulance services related to accidents.

Exclusions listed in the policy apply to the Supplemental Accident rider. For KeyCare HSA, this optional coverage does not cover any of the other capped benefits (benefits with yearly limits) listed in the Limitations section. The coverage also does not cover out-patient therapy related to accidents, because these services are covered under your base policy. Similarly, insulin or other prescription drugs that you will use at home are covered under your base policy, not the optional coverage.

For KeyCare HealthSmart and KeyCare HealthSmart with Enhanced Drug Benefit, the optional coverage does not cover insulin and other prescription drugs, including specialty drugs, as they are covered under the base policy.

Limitations

These policies cover certain services up to a preset limit. Your policy will have detailed information on the benefit limitations that are outlined below. Please call your Anthem Sales Representative if you have questions about limitations.

Benefits with Yearly Limits under these Policies are:

Benefit	Limit Per Calendar Year
· ground ambulance services	\$3,000
· durable medical equipment	\$5,000
· early intervention services (up to age 3)	\$5,000
· manual medical interventions (spinal manipulation)	\$500
· outpatient physical therapy and/or occupational therapy	\$2,000
· outpatient speech therapy	\$500
· home health care services	90 visits
· mental health & substance abuse services	20 outpatient visits; 25 inpatient days. Up to 10 inpatient days may be exchanged for 15 partial days. (1 inpatient day = 1.5 partial days.)
· skilled nursing facility stays	100 days

Prescription Drugs (non-specialty drugs)

· Prescription Drugs	\$5,000
· Dispensed at Pharmacy	Up to a 34 day supply, or no more than 150 units per prescription, which ever is less.
· Ordered through the Home Delivery Pharmacy Service	Up to a 90 day supply per prescription.

Coinsurance limitations

There are some coinsurance amounts you are always responsible for, even when you have met your deductible and out-of-pocket expense limit, and even if your coinsurance choice for your base policy is 0%:

For KeyCare HealthSmart with Enhanced Prescription Drug Benefit:

- coinsurance and copayments for prescription drugs and insulin.

Dental Coverage limitations

Diagnostic

- All covered diagnostic evaluations (whether emergency or non-emergency): 2 each calendar year

Radiographic

- Set of bitewing x-rays (not in same year as full mouth series x-rays): 1 each calendar year
- Full mouth series x-rays for covered persons age 5 and over: 1 every 3 calendar years
- 9 or more bitewing or periapical x-rays taken at one time is considered a full mouth x-ray
- Up to 4 individual periapical films, but not in the same year as a complete mouth x-ray series, (does not apply when rendered in conjunction with emergency treatment.)

Preventive

- Dental cleaning, including periodontal cleanings: 2 each calendar year
- Fluoride application for covered persons under age 16: 2 each calendar year
- Space maintainers for covered persons under age 12: 2 each per lifetime
- Sealants for each unrestored permanent first and second molar for covered persons under age 16: 1 each per lifetime. There must be a lapse of a least 2 years from the time sealants are placed and the time a restoration is performed on the same tooth and surface for benefits to apply.

Restorative

- 1 amalgam or resin restoration (filling) per tooth per surface: 1 per calendar year. White-colored composite resin fillings will only be covered on anterior (front) teeth. If composite resin fillings are done on back teeth, then you are responsible for the difference between our allowable charge and the dentist's charge for amalgam filling restoration
- 1 pin retention per tooth per calendar year
- 1 stainless steel crown on each primary (baby) tooth: 1 each per lifetime

Endodontics

- Root canal; (anterior, bicuspid or molar) : 1 per tooth every 3 calendar years
- Retreat of previous root canal; (anterior, bicuspid, or molar): 1 per tooth per lifetime
- Apicoectomy/periradicular surgery; (anterior, bicuspid, molar, or additional root) : 1 per root or tooth per lifetime
- Retrograde filling: 1 per root or tooth per lifetime
- Root canals are covered only on permanent teeth:
- Therapeutic pulpotomy are covered only on primary (baby) teeth

Periodontics

- Periodontal cleaning (applies to your 2 cleanings per year):
 - 1 per calendar year
- Periodontal scaling and root planing:
 - 1 per quadrant every 2 calendar years
- Gingivectomy or gingivoplasty:
 - 1 per quadrant every 3 calendar years
- Periodontal osseous (bone) surgery:
 - 1 per quadrant every 3 calendar years
- Full mouth debridement: 1 per lifetime

Prosthodontics

- Services for bridges, crowns, and dentures are only covered for teeth extracted or missing after the rider's effective date, which includes initial placement, unless for an existing bridge more than 5 years old
- Adjustment or repair to partial or complete dentures:
 - 1 per calendar year
- Chairside relining of partial or complete dentures:
 - 1 every 2 calendar years
- 1 only, crown or bridge per tooth every 5 calendar years
- 1 partial or complete denture every 5 calendar years
- 1 laboratory rebasing or relining of dentures every 5 calendar years
- 1 crown repair per tooth per lifetime
- 1 crown recementation per tooth per lifetime

Oral Surgery

- Use of anesthesia only in conjunction with surgical procedures
- 1 vestibuloplasty every 3 calendar years

Adjunctive

- 1 palliative (emergency) treatment per calendar year.
- Use of anesthesia only in conjunction with surgical procedures.

**Preventive Care and Immunizations for Children
Coverage limitation**

Visits are limited to the child's initial examination as a newborn and outpatient visits at specific age intervals. Call your Anthem sales representative for more details.

Important Information You Should Know

We're Committed to Your Privacy

As technology and communication capabilities continue to expand each year, so have concerns about the accessibility of private information. At Anthem, we take your privacy very seriously. The following is a brief outline of the steps we've taken to keep your information safe.

The confidentiality of your medical records is not just protected by law; Anthem goes beyond the law's requirements to ensure your privacy. We require all our employees to sign confidentiality statements keeping your records private. We also contractually require participating health care professionals to keep your medical records confidential. Any medical information we receive on your behalf — to help process your claims, for example — is kept secure and access to this information is limited to approved employees. And for added protection, our offices have employee security systems that tightly control access.

When claims data is used in measurement and quality reporting, everyone involved in the analysis signs a confidentiality agreement and findings are reported in ways that do not identify individual patients.

The Virginia Insurance and Privacy Protection Act prohibits the disclosure of personal, privileged or confidential information by an insurer to another party without written authorization from the individual. The law recognizes, however, that in a limited number of situations, an insurer may need to release confidential information without written authorization in order to administer benefits — coordinating care between your primary care physician and your specialist, for example. When your authorization is required, we will not release any information until we receive your (or your legal representative or guardian's) written permission.

An Extra Measure of Coordination and Support

Our plans have several programs and features in place to help coordinate your care as an extra measure of support for you and your family.

These programs include:

Admission Review, which is required before all hospital admissions, (except for maternity admissions without complications). Admission Review ensures that you or your family members are receiving the most appropriate care, in the most appropriate setting. Anthem must approve a hospital admission in order for you to receive benefits for that stay.

Network physicians will arrange for Admission Review approval on your behalf. However, if you are treated by a non-network provider, you are responsible for making sure the doctor obtains Admission Review approval. We will respond within 24 hours after notification, unless we need more information to make a decision. For emergency inpatient services, your doctor, you or a family member must contact us within 48 hours of the admission or on the next business day.

Concurrent Review and Discharge Planning, which helps assess the ongoing need for inpatient care and helps plan for the patient's treatment after discharge. Individual Case Management, a program designed to assist the planning of ongoing care for patients with a catastrophic illness or injury. This service helps our customers coordinate their medical services and/or equipment.

PRESCRIPTION DRUG BENEFITS

Here are some important facts about our prescription drug benefits:

Prior Authorization

We require prior authorization, or advance approval, for certain prescription drugs, or for quantities that exceed the amount ordinarily prescribed or ordered.

To obtain coverage for drugs requiring prior authorization, your physician will need to send a written request along with a copy of applicable medical records. If you choose to purchase these and certain other medications without first getting approval, you will have to pay the full cost. You can find out more about the prior authorization process, including a full list of drugs that require prior authorization, by calling your Anthem Sales Representative.

Generic vs. Brand Name Drugs

Generic Drugs are a cost-saving alternative to brand name drugs. They are regulated by the Federal Drug Administration (FDA), and contain the same active ingredients in the same dosage as the original brand name product.

With KeyCare HealthSmart with Enhanced Prescription Drug Benefit, you will receive the highest level of benefits by asking your physician to prescribe a generic drug whenever possible. If you choose to purchase a brand name drug when a generic drug is available, you will be responsible for the difference in cost between brand and generic, plus your copayment or coinsurance.

Sometimes physicians prescribe medications to be dispensed as written when there are generic alternatives available. To help save money, network pharmacists may discuss with those physicians whether an alternative drug might be appropriate. Physicians always make the final decision on the medications they prescribe.

Coordination of Benefits

If you choose to be covered by two or more types of health insurance, it's important to know our Coordination of Benefits procedures.

Anthem Blue Cross and Blue Shield policies all have a coordination of benefits provision. This provision explains that if you are issued an Anthem Blue Cross and Blue Shield individual policy, and one of the persons covered by your Anthem policy is covered by a group health plan, the group health plan will have primary responsibility for the covered expenses of that family member.

For any dependent children on your Anthem individual policy who are enrolled under another individual health plan, the primary policy is the policy of the parent whose birthday (month and day) falls earlier in the calendar year. Parent birth year is not considered.

This is not your policy and is intended as a brief summary of services. If there is any difference between this brochure and the policy, the provisions of the policy shall control. This brochure refers to Policy Form #s 901119-CP.1 et al., Schedule of Benefits Form #s AVA1515 and PVA1721 and Application Form #s AVA1529, AVA1533, AVA1536, AVA1313 or AVA1537, AVA1359, or AVA1572 and optional coverage form #s AVA1393, AVA1517, 901167 and 901165 or AVA1563.

Questions?

For more information about Anthem Individual KeyCare Plans, contact your Anthem Sales Representative. Or, for more information, please visit our Web site at www.anthem.com.

For more information, visit our Web site at [anthem.com](http://www.anthem.com)



Our service area is Virginia, excluding the city of Fairfax, the town of Vienna, and the area east of State Route 123.
Anthem's KeyCare PPO Network is only available in certain parts of Virginia.

Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Virginia, Inc.
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Important Information About Your Personal Health Care Coverage

We recently changed the names of special services or clarified certain issues pertaining to your Anthem Blue Cross and Blue Shield health care coverage.

Unless otherwise noted, the following changes are effective as of July 1, 2007:

Pharmacy Name Change

In January 2007, our mail order pharmacy changed its name to WellPoint NextRx. The new name reflects Anthem's efforts to integrate our pharmacy companies and bring you quality service. While the name has changed, everything else remains the same, including your prescription drug benefits, phone numbers, web sites, hours of operation, current support resources, and the delivery of benefits and service.

Our mail service pharmacy is specifically designed for members who take maintenance medications on a regular basis for longer periods of time. This includes medications used to treat chronic conditions such as high cholesterol, diabetes, high blood pressure, arthritis, or depression, as well as medications used on a regular basis, such as oral contraceptives. You can learn more about our mail service pharmacy by visiting our Web site at:

[Anthem.com](#) > [Members](#) > [Virginia](#) > [Plans and Benefits](#) > [Prescription](#) > [Mail Service Pharmacy](#)

Special Program Name Changes

We've changed the names of some of our special programs that are added features but not an actual part of your policy or benefits. These added features can be modified or discontinued at our discretion. Here are the new names effective July 1, 2007:

<u>Previous Name</u>		<u>New Name</u>
Baby Benefits	=>	Future Moms
Better Prepared	=>	ConditionCare

Alcohol Exclusion Removed

We have removed the exclusion regarding alcohol, intoxicants and illegal substances from your health care contract. However, all other limitations and exclusions continue to apply. This change affects services for dates of service of July 1, 2007 and after.