Exclusions: Services Not Covered

This list of services and supplies is excluded from coverage and will not be covered in any case. Anthem KeyCare and Anthem BlueCare plans offered by Anthem Blue Cross and Blue Shield do not provide benefits for the following:

• Acupuncture. •Biofeedback therapy. • Over the counter convenience and hygienic items. These include, but are not limited to, adhesive removers, cleansers, underpads, and ice bags. • Benefits for, or related to cosmetic surgery or procedures, including complications that result from such surgeries and/or procedures. Cosmetic surgeries and procedures are performed mainly to improve or alter a person's appearance including body piercing and tattooing. However, a cosmetic surgery or procedure does not include a surgery or procedure to correct deformity caused by disease, trauma, or a previous therapeutic process. Cosmetic surgeries and/or procedures also do not include surgeries or procedures to correct congenital abnormalities that cause functional impairment. We will not consider the patient's mental state in deciding if the surgery is cosmetic. • The following dental services: treatment of natural teeth due to diseases or treatment of natural teeth due to accidental injury occurring on or after the effective date of coverage, unless treatment was sought within 60 days after the injury and the member submitted a treatment plan to Anthem for prior approval; dental care, treatment, supplies, or dental x-rays; damage to teeth due to chewing or biting is not deemed an accidental injury and is not covered; oral surgeries or periodontal work on the hard and/or soft tissue that supports the teeth meant to help the teeth or their supporting structures; appliances for temporomandibular joint pain dysfunction; and periodontal care, prosthodontal care or orthodontic care. This exclusion will not apply if your group's coverage includes a dental rider. • Coverage does not include donor searches for organ and tissue transplants, including compatibility testing of potential donors who are not immediate, blood related family members (parent, child, sibling). • Educational or teacher services except in limited circumstances. • Experimental/investigative procedures, as well as services related to or complications from such procedures except for clinical trial costs for cancer as described by the National Cancer Institute. Nothing in this exclusion will prevent a member from appealing our decision that a service is experimental/investigative. • The following family planning services: birth control medicine and devices unless prescribed for reasons other than birth control; services for interruption of pregnancy including any drugs administered in connection with these services; services for surgical sterilization, including tubal ligation and vasectomy procedures; services for artificial insemination or in vitro fertilization or any other types of artificial or surgical means of conception including any drugs administered in connection with these procedures; drugs used to treat infertility; or reversals of sterilization. • Services for palliative or cosmetic foot care including: flat foot conditions; support devices, arch supports, foot inserts, orthopedic and corrective shoes that are not part of a leg brace and fittings, castings and other services related to devices of the feet; foot orthotics; subluxations of the foot; corns; bunions (except capsular or bone surgery); calluses; care of toenails; fallen arches; weak feet; chronic foot strain; or symptomatic complaints of the feet. • Routine hearing care or hearing aids or exams for these devices except as described in the brochures and enrollment materials. • The following home care services: homemaker services; maintenance therapy; food and home delivered meals; or custodial care and services. • The following hospital services: guest meals, telephones, televisions, and any other convenience items received as part of your inpatient stay; care by interns, residents, house physicians, or other facility employees that are billed separately from the facility; or a private room unless it is medically necessary. • Coverage does not include maternity benefits for your unmarried children. • Medical equipment (durable), appliances and devices, and medical supplies that have both a non-therapeutic and therapeutic use. These include: exercise equipment; air conditioners, dehumidifiers, humidifiers, and purifiers; hypoallergenic bed linens; whirlpool baths; handrails, ramps, elevators, and stair glides; telephones; adjustments made to a vehicle; foot orthotics; changes made to a home or place of business; or repair or replacement of equipment lost or damaged through neglect. • Services or supplies if they are deemed not medically necessary as determined by Anthem at its sole discretion. Nothing in this exclusion shall prevent the member from appealing Anthem's decision that a service is not medically necessary. However, if you receive inpatient or outpatient services that are denied as not medically necessary, or are denied for failure to obtain the required pre-authorization or referral, the following professional provider services that you receive during your inpatient stay or as part of your outpatient services will not be denied under this exclusion in spite of the medical necessity denial of the overall services: For inpatients 1): services that are rendered by

professional providers who do not control whether you are treated on an inpatient basis, such as pathologists, radiologists, anesthesiologists, and consulting physicians. 2): services rendered by your attending provider other than inpatient evaluation and management services provided to you. Inpatient evaluation and management services include routine visits by your attending provider for purposes such as reviewing patient status, test results, and patient medical records. Inpatient evaluation and management visits do not include surgical, diagnostic, or therapeutic services performed by your attending provider. For outpatients: services of pathologists, radiologists and anesthesiologists rendering services in an outpatient hospital setting, emergency room, or ambulatory surgery setting. However, this exception does not apply if and when any such pathologist, radiologist or anesthesiologist assumes the role of attending physician. • The following mental health services and substance abuse services: inpatient stays for environmental changes; cognitive rehabilitation therapy; educational therapy; vocational and recreational activities; coma stimulation therapy; services for sexual deviation and dysfunction; treatment of social maladjustment without signs of a psychiatric disorder; remedial or special education services; or inpatient mental health treatments that meet the following criteria: more than 2 hours of psychotherapy during a 24-hour period in addition to the psychotherapy being provided pursuant to the inpatient treatment program of the hospital; group psychotherapy when there are more than 8 patients with a single therapist; group psychotherapy when there are more than 12 patients with two therapists; more than 12 convulsive therapy treatments during a single admission; or psychotherapy provided on the same day of convulsive therapy. • Nutrition counseling and related services, except when provided as part of diabetes education. • Care of **obesity** or services related to weight loss or dietary control, including complications that directly result from such surgeries and/or procedures. This includes weight reduction therapies/activities, even if there is a related medical problem. Notwithstanding provisions of other exclusions involving cosmetic surgery to the contrary, services rendered to improve appearance (such as abdominoplasties, panniculectomies, and lipectomies), are not covered services even though the services may be required to correct deformity after a previous therapeutic process involving gastric bypass surgery. Coverage for morbid obesity is available through an optional coverage rider at extra cost. Details on request. • Organ or tissue transplants, including complications caused by them, except when they are considered medically necessary, have received pre-authorization, and are not considered experimental/investigative. Autologous bone marrow transplants for breast cancer are covered only when the procedure is performed in accordance with protocols approved by the institutional review board of any United States medical teaching college. These include, but are not limited to, National Cancer Institute protocols that have been favorably reviewed and used by hematologists or oncologists who are experienced in high dose chemotherapy and autologous bone marrow transplants or stem cell transplants. This procedure is covered despite the exclusion in the plan of experimental/investigative services. • Paternity testing. • Prescription drug benefit does not include coverage for: over the counter drugs; any per unit, per month quantity over the plan's limit; drugs used mainly for cosmetic purposes; drugs that are experimental, investigational, or not approved by the FDA; cost of medicine that exceeds the allowable charge for that prescription; birth control medications or devices; drugs for weight loss; stop smoking aids; therapeutic devices or appliances; injectable prescription drugs that are supplied by a provider other than a pharmacy; charges to inject or administer drugs; drugs not dispensed by a licensed pharmacy; drugs not prescribed by a licensed provider; any refill dispensed after one year from the date of the original prescription order; medicine covered by workers' compensation, Occupational Disease Law, state or government agencies; or medicine furnished by any other drug or medical service. Coverage does not include benefits for prescription drugs received through an outpatient pharmacy. • Private duty nurses in the inpatient setting. • Rest cures, custodial, residential, or domiciliary care and services. Whether care is considered “residential” will be determined based on factors such as whether the member receives active 24-hour skilled professional nursing care, daily physician visits, daily assessments, and structured therapeutic services. Coverage does not include benefits for care from institutions or facilities that are licensed solely as residential treatment centers, intermediate care facilities, or other non-skilled, sub-acute inpatient settings. • Services or supplies if they are: ordered by a doctor whose services are not covered under the health plan*;* care of any type given along with the services of an attending provider whose services are not covered; not listed as covered under the health plan*;* not prescribed, performed, or directed by a provider licensed to do so; received before the effective date or after a covered person's coverage ends; or telephone consultations, charges for not keeping appointments, or charges for completing claim forms. • Services or supplies if they are: for travel, whether or not recommended by a physician; given by a member of the covered person's immediate family; provided

under federal, state, or local laws and regulations. This includes Medicare and other services available through the Social Security Act of 1965, as amended, except as provided by the Age Discrimination Act. This exclusion applies whether or not *you* waive your rights under these laws and regulations. It does not apply to laws that make the government program the secondary payor after benefits under this policy have been paid. Anthem will pay for covered services when these program benefits have been exhausted; provided under a U. S. government program or a program for which the federal or state government pays all or part of the cost. This exclusion does not apply to health benefits plans for civilian employees or retired civilian employees of the federal or state government; received from an employer mutual association, trust, or a labor union's dental or medical department; or for diseases contracted or injuries caused because of war, declared or undeclared, voluntary participation in civil disobedience, or other such activities. • Services for which a charge is not usually made. This includes services for which you would not have been charged if you did not have health care coverage. • Services or benefits for: amounts above the allowable charge for a service; self administered services or self care; self-help training; or biofeedback, neurofeedback, and related diagnostic tests. • Benefits for surgeries for sexual dysfunction. In addition, your coverage does not include benefits for services for sex transformation. This includes medical and mental health services. • The following skilled nursing facility stays*:* treatment of psychiatric conditions and senile deterioration; or facility services during a temporary leave of absence from the facility. • Benefits for services related to smoking cessation, including stop smoking aids or services of stop smoking clinics. • Spinal manipulations or other manual medical interventions for an illness or injury other than musculoskeletal conditions. • The following therapies: physical therapy, occupational therapy, or speech therapy to maintain or preserve current functions if there is no chance of improvement or reversal except for children under age 3 who qualify for early intervention services; group speech therapy; group or individual exercise classes or personal training sessions; or recreation therapy. This includes, but is not limited to, sleep, dance, arts, crafts, aquatic, gambling, and nature therapy. • The following vision services: vision services or supplies unless needed due to eye surgery and accidental injury; services for radial keratotomy and other surgical procedures to correct nearsightedness and or farsightedness. This type of surgery includes keratoplasty and Lasik procedure; services for vision training and orthoptics; tests associated with the fitting of contact lenses unless the contact lenses are needed due to eye surgery or to treat accidental injury; or any other vision services not specifically listed as covered. • Services or supplies if they are for work-related injuries or diseases when the employer must provide benefits by federal, state, or local law or when that person has been paid by the employer. This exclusion applies even if you waive your right to payment under these laws and regulations or fail to comply with your employer's procedures to receive the benefits. It also applies whether or not the covered person reaches a settlement with his or her employer or the employer's insurer or self insurance association because of the injury or disease.

Limitations for Anthem KeyCare and Anthem BlueCare Plans

All policies cover certain services up to a preset limit. For example, visits with a health care provider may be limited by the number of visits, or services may be limited by a maximum dollar amount. Once a member reaches the preset limit on a service, the policy will not pay benefits for that service for the rest of the calendar year. (A calendar year runs from January 1 to December 31.)

Benefits with Yearly Limits

• Durable medical equipment	$5000
• Early Intervention Services (combined maximum; up to age 3)	$5000
• Manual medical intervention (includes spinal manipulation)	$500
• Outpatient private duty nursing	$500
• Ground Ambulance Services	$3000
• Physical and occupational therapy (combined maximum)	$2000
• Speech therapy	$500
• Home health care services	90 visits*
• Skilled nursing care	100 days per confinement

**Limit applies to KeyCare 10, KeyCare 10 Plus, KeyCare 15, KeyCare 15 Plus, KeyCare 20, KeyCare 20*

Plus, BlueCare 15 and BlueCare 20.

Limitations for Out-of-Pocket Expenses
The health plans protect members from large out-of-pocket expenses by limiting the amount they spend out-of-pocket each year. Once the limit has been reached, almost all other covered expenses are paid in full for the remainder of the calendar year. The following do not count toward a member's out-of-pocket expense limits for covered services:

- Deductibles, copayments and coinsurance for care received in a facility that does not participate in an Anthem or Blue Cross Blue Shield company's network
- Amounts above the allowable charge
- Amounts above health plan limits
- Expenses for prescription drugs under the prescription drug benefit
- Expenses for routine vision care
- Expenses for supplies or services not covered by the health plan
- Expenses for dental services provided by separate contract, certificate, or amendment to the health plan

This information is not a contract or policy. It is a summary and partial description of benefits available through Anthem KeyCare and Anthem BlueCare plans. If there are any differences between this information and the group policies, the provisions in the group policy will govern. More details about benefits, exclusions and restrictions can be found in the group policies and endorsements.

Anthem KeyCare and Anthem BlueCare Products:
GP-1 (7/02) et al; PP-INTRO (7/04); P-TOC (7/04); P-SB1 (1/05); P-SB2 (1/05); P-SB3 (1/05); P-SB4 (1/05); P-WORKS (1/05); P-COVERED (1/05); P-EXCL (1/05); P-CLAIMS (7/04); P-COB (1/05); P-ENR (1/04); P-ENDS (1/05); P-INFO (10/04); P-RIGHTS (1/05); P-DEF (1/05); P-EXH-A (7/04); P-INDEX (7/04), P-ACC (3/00); V-INTRO (7/03), V-TOC (7/03), V-WORKS (1/05), V-COVERED (1/05), V-EXCL (7/02), V-CLAIMS (7/02), V-ENR, V-INFO (1/05), V-DEF (7/02) and V-INDEX (7/03).

Anthem Blue Cross and Blue Shield's service area for the sale of its policies is the Commonwealth of Virginia excluding the city of Fairfax, the town of Vienna and the area east of State Route 123. However, Anthem Blue Cross and Blue Shield's provider networks include doctors, hospitals and other health care professionals located in those areas and in other contiguous regions outside of the Anthem Blue Cross and Blue Shield service area.