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

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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:

Previous Name		New Name
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.

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Individual Basic℠ BlueCare

At Anthem Blue Cross and Blue Shield, we understand that individual health insurance is about finding coverage that fits *you*. That's why we offer a traditional coverage option in addition to our PPO network plans. If you live outside our PPO network service area, or simply prefer coverage without network restrictions, Individual Basic BlueCare may be right for you. So take a few minutes to review our Individual Basic BlueCare plan. We think you'll find the coverage you need and the convenience you want — all with the strength and service of Anthem Blue Cross and Blue Shield standing behind your coverage.

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Anthem®

Important Terms

When you see this symbol, you'll know that we're describing a cost-saving feature available with Anthem.

Before you look at the plan benefits, you may find it helpful to review some important terms we use throughout this information. You'll also want to review the Important Facts You Should Know on pages 10 - 15, for details about policy terms, exclusions and limitations.

Allowable Charge: The allowance Anthem determines for covered services.

Annual Deductible: The amount you pay toward covered health care services each calendar year before receiving certain benefits. Deductibles apply to each covered person. However, we do provide a family deductible. Once two or more covered persons meet two times the individual deductible, no other deductible has to be met for the family for the rest of the year. It's important to note that choosing a higher deductible will lower your monthly premium.

Annual Out-of-Pocket Expense Limit: The amount you are responsible for paying out of your pocket for covered services in one calendar year after your yearly deductible. Your annual out-of-pocket expense limit helps protect you from high dollar medical costs. After you pay your yearly deductible, the out-of-pocket expense limit helps to cap the total coinsurance amount you are responsible for paying each benefit period. There are some amounts you are always responsible for paying. Please see the out-of-pocket expense limit exclusions listed in the Important Facts brochure.

Anthem Participating Providers and Pharmacies: These medical professionals or facilities accept Anthem's allowable charge as payment in full, so even if you haven't met your deductible, you can still save on the cost of covered services when you visit a participating provider or pharmacy. Non-participating providers or pharmacies may not accept Anthem's allowable charge as payment in full. You will be required to pay the amount over the allowable charge for the covered service and your claims may not be filed automatically. Log on to **anthem.com** today to review our list of participating providers and pharmacies.

Coinsurance: The percentage of the allowable charge you pay for services covered by your policy after you meet your deductible.

Lifetime Maximum Benefit: This is the maximum amount we will cover during the lifetime of your policy for each covered person.

Individual Basic BlueCare

Individual Basic BlueCare is our low-cost traditional plan. It provides coverage for doctor visits and other outpatient services, emergency and inpatient care, plus prescription drugs and routine wellness services after you meet all applicable deductibles. So if you're looking for the convenience of a traditional plan at a low cost, Basic BlueCare may be right for you.

The Basics	"The Basics" are the foundation of your coverage. They determine how your plan works and explain your share of the costs for covered services.
Provider/Facilities	You can choose any doctor or hospital, but keep in mind that you'll save more on the cost of covered services by visiting a participating provider. See page 2 for more information.
Freedom to use any provider or hospital.	
Annual Deductible/Coinsurance	**All services require a deductible unless otherwise stated.** The annual deductible you choose affects your level of coinsurance. With larger deductibles, you pay more out of your pocket before benefits begin, so we typically set your coinsurance at 0%. This plan also includes a family deductible, which is two times the individual deductible, when met by two or more covered persons.
$300, $750, $1,500 20% coinsurance **$2,500, $5,000** 0% coinsurance	
Annual Out-of-Pocket Expense Limit (after your deductible)	The deductible you choose determines your annual out-of-pocket expense limit. Basic BlueCare has a family out-of-pocket expense limit which is similar to our family deductible. There are certain coinsurance amounts that don't count toward your out-of-pocket expense limit. See the Important Facts brochure for more details.
$300, $750, $1,500 deductibles $2,000 single $4,000 family **$2,500, $5,000 deductibles** none	
The Benefits	Please note that the benefits listed apply to each covered person on the policy.
Lifetime Maximum Benefit	
$2 million regardless of providers or facilities	
Hospital Inpatient Services	
You pay 20% or 0% coinsurance, after deductible	
Emergency Care	Emergencies include cardiac arrest, appendicitis, heat stroke or other severe medical conditions.
You pay 20% or 0% coinsurance, after deductible	
Prescription Drugs	If you choose a brand name drug when a generic alternative is available, you'll be responsible for the difference in cost between brand and generic, plus the copayment or coinsurance amount. You can also save more on the cost of covered prescription drugs by visiting participating pharmacies.
$200 separate deductible per person per calendar year. Prescription card: You pay a $10 copayment or 40% coinsurance, whichever is greater. $5,000 annual maximum benefit for covered prescriptions. You receive maximum benefits when you purchase generic drugs, when available.	

Individual Basic BlueCare

The Benefits

Outpatient Care

Doctor Visits

You pay 20% or 0% coinsurance, after deductible

Routine Wellness Care

You pay 20% or 0%* coinsurance after deductible

2 preventive office visits per year.
Provides an additional $150 per year for immunizations, labs, and x-rays.

Routine wellness benefits are as follows:

Service	Age	Frequency
Office visits for routine wellness services	7 and older	2 per year
Pap Smear	Any age	1 per year
Mammography Screening	35 and older	1 per year
Prostate Cancer Screening	50 and older (40-49 if at high risk)	1 PSA test and prostate exams as needed per year
Colorectal Cancer Screenings (Flexible Sigmoidoscopy, Colonoscopy, or Barium Enema in appropriate circumstances)	As recommended by the American College of Gastroenterology and the American Cancer Society	
Additional routine care/immunizations	7 and older	As recommended by physician

Preventive Care and Immunizations for Children

You pay 0% coinsurance. **No deductible.**

Provides preventive care, such as medical visits, lab tests, vision and hearing screenings, as well as immunizations from birth through age 6.

Other Outpatient Services

You pay 20% or 0% coinsurance, after deductible

Additional Benefits Available

– Dental (includes coverage for preventive, restorative & complex services)
– Maternity
– Supplemental Accident

To help supplement your core benefits, you can purchase riders at a separate cost to help complete your overall health protection package.

* If you choose 0% coinsurance, that 0% applies to covered routine mammograms and colorectal cancer screenings.

Mental Health Services: Covers 25 inpatient days after deductible at 20% or 0% coinsurance. Covers 20 outpatient visits which are subject to your deductible: 20% coinsurance for visits 1-5, and 50% coinsurance for visits 6-20.

Benefits Available at an Additional Cost

Otherwise known as "Riders"

Not everyone wants or needs specialty benefits included in their plan's core benefits. That's why we offer "riders," or optional coverage that you can add to your plan, so you can tailor your coverage to help meet your needs. Even if you don't need the extra protection now, riders can always be added at 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 covered dependent, reaching age 65 or becoming eligible for Medicare, a court order, an insured or covered spouse or domestic partner changing or losing their job, or entering military service). However, with Basic BlueCare, the dental rider can be purchased at the first of every month.

Dental Rider

With Basic BlueCare, we offer preventive, restorative and complex care services to help protect your smile.

Dental Rider Benefits for Individual Basic BlueCare

With Basic BlueCare, you'll save more on the cost of covered services when you visit a network dentist. If you go out-of-network for dental care, you'll be responsible for more of the cost and you'll have 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 *(Oral Exams)*	None	0%	50%	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)*						

Benefits Available at an Additional Cost

Dental Rider Benefits (cont'd.)

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	$100	$1,000 per covered person for preventive, restorative and complex care
Simple Extractions						
Anesthesia *(for emergency treatment of dental pain for minor procedures, general anesthesia with oral surgery)*						
Oral Surgery *(includes root removal, treatment of abscess)*	18 months			$150 per family	$300 per family	
Prosthodontic Services *(includes onlays, crowns, dentures)*						
Endodontic Services *(root canals)*						
Periodontal Services *(includes periodontal cleaning, scaling, and root planing)*						

Benefits Available at an Additional Cost

Maternity Rider

If you're hoping to add to your family any time in the future, you may want to think about adding a maternity rider now. The maternity rider 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 laboratory charges.

It's important to plan ahead for maternity coverage:

- Conception must occur at least 6 months after the rider effective date in order to receive coverage, even if you qualify for credit toward your base policy's waiting period.
- If you are a HIPAA-eligible individual as defined on Anthem's coverage application included with this brochure, and conception occurred prior to the effective date of the maternity rider, you will not have to wait 6 months before your coverage begins. Your Anthem Sales Representative has more details.
- Please note that maternity coverage cannot be added to a policy insuring one male without a female spouse or domestic partner on the policy, or for female applicants under age 18 unless they are emancipated minors.

Supplemental Accident Rider

Emergency care is included in all of our plans, but the unexpected costs of an accident can add up. When you visit a participating provider, Anthem will pay 100% of the allowable charge, up to $500 for each accident or injury. Plus, you don't have to meet any deductible before you begin receiving benefits for covered services, so you save right away. With non-participating providers, your share of the cost will increase.

Anthem and You
A Partnership for a Healthy Lifestyle

The rising cost of health care is a critical issue facing this country. American's spending on health care is expected to double by 2013 to more than $3.6 trillion, consuming nearly one-fifth of our gross domestic product[1]. It's a complex problem caused by many different factors, and it won't be solved easily. But if we all work together - not just health insurers and health care providers, but all health care consumers — we can make a real difference in rising medical costs.

At Anthem Blue Cross and Blue Shield, we're working to find ways to help keep the cost of health care, and health insurance, affordable for everyone. As part of that effort, Anthem is pleased to provide our members with discounts on health-related products and services. We offer these discount programs to add value to our members' benefits and to encourage a healthy lifestyle. All you'll need to take advantage of these discounts is your Anthem identification card. Because the discount programs are not part of nor guaranteed by our policies, there are no claims to file, no dollar limits, and the programs add nothing to the cost of coverage.[2]

SpecialOffers@Anthem

Through our *SpecialOffers@Anthem* program, you can receive discounts on everything from alternative medicine to fitness center memberships, weight loss and smoking cessation programs, health and wellness books, allergy supplies, cosmetic dentistry, hearing and vision care, maternity needs and more. For more information about the discount options available to you, just visit **anthem.com**. Click on the Members tab and choose Virginia as your state. From the Members page, click on *Answers@Anthem* and then select the *SpecialOffers@Anthem* link. You may be surprised at the information you'll find. Log on to **anthem.com** today and find out why being an Anthem member has its advantages.

Did You Know...

If you're self-employed, your individual health insurance premiums may be tax-deductible — which is one more way you could save on your health care costs. Contact your financial advisor or visit www.irs.gov for details.

[1] http: www.cms.hhs.gov; National Healthcare Expenditures; Projections: 2004-2014, February 24, 2005.

[2] Because these discount programs are not part of nor guaranteed by the policy, they can be modified or discontinued at our discretion.

Anthem and You
A Partnership for a Healthy Lifestyle

What else is Anthem doing to help keep my health care costs low?

In Virginia alone, Anthem receives more than 3 million health care claims a month[1]. This enormous amount of information helps us identify ways to help keep the cost of health care, and health insurance, as low as possible. We have more than 80 programs[1] dedicated to reducing health care costs and improving quality for our members. Here are just a few:

Drug Therapy Alerts

This program helps protect our customers from the dangers of drug-to-drug interactions and over/under use of medications. When our systems identify a customer at risk, Anthem's pharmacy team alerts the prescribing physician and offers possible solutions. Since 10-25% of hospitalizations are related to drug therapy problems[2], Drug Therapy Alerts not only improves patient care, it manages health care costs, too.

Preventive Care Benefits

Preventive care helps keep people healthy, and keeps health care costs down for everyone. Anthem promotes the use of preventive care by making coverage available for recommended cancer screenings, annual exams, certain immunizations, lab work and x-rays in all its health plans.

Online Decision Tools

When you're faced with a health care decision, the more you know, the better. At Anthem, we provide online tools to help our customers have informed discussions with their doctors, consider all the treatment options available to them, the possible outcomes, and the cost implications.

Hospital Quality Comparison and Treatment Decision Support

Our online Hospital Quality Comparison Tool is available to any Anthem member who registers on **anthem.com**. The tool gives comparative hospital data such as patient volume, infection and mortality rates, and cost of services, so that you can make a value-based decision. Our online Treatment Decision Support Tool gives detailed information on nearly 60 conditions and procedures, including possible treatment options, possible complications and risks, and questions to ask your doctor.

Online Drug Listing

The Online Drug Listing at **anthem.com** gives Anthem members information about medication costs, indications, possible alternatives and how their benefits will cover the drugs. This allows members to select a drug that will provide appropriate treatment for the best value.

[1] Anthem Blue Cross and Blue Shield Service Operations, September 2006.

[2] Einerson, TR. Drug-related Hospital Admissions. Annals of Pharmacotherapy; 1993;27:832-840.

Important Facts 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 hospital admissions, with the exception of hospital stays for maternity deliveries without complication. 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 Individual Basic BlueCare, 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.

Policy Terms
The following are provisions to our policies, that outline specific requirements and procedures about our plans. However, keep in mind that this brochure is not your official policy. If there is any difference between this brochure and the policy, the provisions of the policy shall control.

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;*
- 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.

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 not related by blood in a way that would prohibit marriage.

Eligible children must also be:
- unmarried; and
- under age 23.

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, 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, gender, 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 policy described in this brochure is an individual health insurance policy, and, as such, cannot be used as an employer-provided health care benefit plan. No employer of any covered person under this policy 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/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 person begins active duty with the Armed Services;
- death of the dependent; or
- at the insured's request.

In addition, coverage ends for covered dependent children under these circumstances:
- at the end of the year in which a covered child turns 23; or
- when the child marries.

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.

* 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.

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 also what it does not cover.

Exclusions:

Our Individual Basic BlueCare policy does 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 plan in this brochure does not cover prescription drugs prescribed for a pre-existing condition, and services for, or complications resulting from, a pre-existing condition.

This exclusion does not apply to properly added newborns and adopted children, or in certain cases of breast cancer follow-up care. If a covered person has been free of breast cancer for five years or more, based on follow-up medical care that shows negative test results, then the follow-up care they received in the 12 months prior to their effective date will not be considered when determining pre-existing conditions.

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, routine x-rays or vaccinations, immunizations or other injections not used to treat a current illness that exceeds 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 scientfic 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 the 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 or Mechanical Interventions

Services over the first $500 paid per benefit period, per covered person, and manual or mechnical interventions other than musculoskeletal illnesses or injuries.

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 other non-skilled, sub-acute settings, except to the extent such setting qualifies as a 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; services for which a charge is not normally made or for which charges have been waived.

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-administered services, including biofeedback and related testing.

Out-of-pocket expense limit exclusions
The following items never count toward your out-of-pocket expense limit:

- amounts we apply to your deductible;
- any coinsurance limitations listed on page 15;
- amounts exceeding the allowable charge;
- expenses for services not covered under the policy; and
- copayments.

Rider exclusions

Adding a rider to your policy changes certain exclusions in your policy related specifically to services for dental care, pregnancy, or accidents. But other limitations and exclusions continue to apply.

Dental rider exclusions for Basic BlueCare
This rider does not cover:

- services not listed or described in your policy or in the rider as a covered service;
- 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 rider;
- upgrading of serviceable dentistry;
- services rendered prior to the rider's effective date, and services rendered on or after the rider's effective date that are directly related to services received before the rider effective date;

Dental rider exclusions for Basic BlueCare (cont'd.)

- services rendered after the date of termination of the rider;
- 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);
- 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 rider exclusions

The maternity rider covers pregnancies that begin at least six months after the rider becomes effective. 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 rider exclusions

The supplemental accident rider covers ambulance services related to accidents, but it does not cover any of the other capped benefits (benefits with yearly limits) listed in the Limitations section. The rider also does not cover outpatient 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 rider.

Limitations

This policy covers 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 this Policy 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

Benefits with yearly limits (cont'd.)

Benefit	Limit Per Calendar Year
· 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.)
· home health care services	90 visits
· skilled nursing facility stays	100 days
Prescription Drugs	
· Prescription Drugs	$5,000
· Dispensed at Pharmacy	Up to a 34 day supply, or no more than 150 units per prescription, whichever 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%:

- coinsurance (which increases to 25%) paid to a non-participating facility;
- coinsurance for manual medical interventions, including spinal manipulation;
- coinsurance and copayments for prescription drugs and insulin;
- coinsurance for Routine Wellness Care, except mammography screenings for ages 35 and older, and colorectal cancer screenings;
- coinsurance for outpatient mental health visits;
- coinsurance for outpatient physical therapy, outpatient speech therapy, outpatient occupational therapy, durable medical equipment, early intervention services and home health care services;
- coinsurance for skilled nursing facility stay.

Dental rider 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 filings 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 onlay, 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.

Questions?

Your Anthem Sales Representative will be glad to help.

Our service area is Virginia, excluding the city of Fairfax, the town of Vienna, and the area east of State Route 123. This brochure is only one piece of your entire fulfillment package. For a summary of benefits, limitations and exclusions, please see pages 10-15 of this brochure. 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 is only one part of your entire fulfillment kit. This refers to Personal Health Care Contract # 901151-CP et al., Application form #s AVA1528, AVA1531, AVA1534, AVA1537, AVA1359 or AVA1459 and Rider form #s AVA1393, AVA1564, and 901167.