Your Health.
Your Security.
Your Choice.

Choosing the right health care plan should be as easy as 1, 2, 3.

We can help.

Anthem®

1 KeyCare® HSA

A high deductible health plan, compatible with a Health Savings Account (HSA).

- Lowest high-deductible premium option, offering solid protection.
- All covered services, except preventive care for children, are covered after the policy deductible is met.

2 KeyCare HealthSmart℠

An affordable high deductible health plan, with deductible options compatible with a Health Savings Account (HSA).

3 KeyCare HealthSmart℠ w/Enhanced Drug Benefit

Offers high deductible health plan savings, with prescription drugs covered before the deductible. Not compatible with a Health Savings Account (HSA).

Why Choose Anthem?

Choices

Choice of plans...because not everyone's health care needs are the same.

Choice of doctors...so you can save with a network plan and still have access to 85% of Virginia doctors[1] — with no referrals or gatekeepers needed.

Experience

With 1.9 million customers, Anthem Blue Cross and Blue Shield protects more Virginians than any other health insurer[2] — and we've been serving Virginians for over 70 years.

High Marks

The National Committee for Quality Assurance (NCQA) has awarded Anthem's KeyCare PPO plans "Full Accreditation" — NCQA's highest level of PPO accreditation.

Financial Strength

AM Best has given us an A (excellent) rating[3].

1 Anthem Blue Cross and Blue Shield Provider Network Report, January 2005.
2 Anthem Market Research, April 2006.
3 AM Best Company as of December 29, 2005.

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.

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.

Employees covered by an Anthem Blue Cross and Blue Shield group plan are not eligible to purchase individual health insurance policies from Anthem. However, spouses, dependents or domestic partners of the employee are eligible to apply for individual policies.

** 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).*

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.

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.

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 provide.

What's Not Covered

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, as well as services related to or complications from such procedures, 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.

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.

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.

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

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.

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.

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

· Prescription Drugs	$5,000[2]
· Dispensed at Pharmacy	Up to a 34 day supply, or no more than 150 units per prescription, which ever is less.
· Ordered through WellPoint Next Rx Mail Service Pharmacy	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.

Some important terms:

Allowable Charge:
The allowance Anthem determines for covered services. Participating providers accept Anthem's allowable charge as payment in full.

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

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

Deductible:
The amount you pay toward covered health care services each calendar year before receiving certain benefits.

Out-of-Pocket Expense Limit:
This is the total amount you are responsible for paying out of your pocket for covered services. It helps control your annual out-of-pocket expenses.

1 KeyCare® HSA

$5 Million Lifetime Benefit

After the **Deductible**, you pay a **Coinsurance amount**, up to an annual **Out-of-Pocket Expense Limit**. This **Expense Limit** helps control **all** your annual out-of-pocket expenses for covered services, including deductible, copayments, and coinsurance.

In Network - Single Coverage

Deductible	Coinsurance	Expense Limit
$ 1,200	20%	$ 3,000
$ 2,250	20%	$ 4,000
$ 3,000	0%	$ 3,000
$ 5,000	0%	$ 5,000

In Network - Family Coverage

Deductible	Coinsurance	Expense Limit
$ 2,400	20%	$ 6,000
$ 4,500	20%	$ 8,000
$ 6,000	0%	$ 6,000
$ 10,000	0%	$10,000

Out-of- Network - Single Coverage

Separate Deductible	Coinsurance	Expense Limit
$ 1,200	30%	$ 4,500
$ 2,250		$ 6,000
$ 3,000		$ 4,500
$ 5,000		$ 7,500

Out-of- Network - Family Coverage

Separate Deductible	Coinsurance	Expense Limit
$ 2,400	30%	$ 9,000
$ 4,500		$12,000
$ 6,000		$ 9,000
$ 10,000		$15,000

2 KeyCare HealthSmart℠

$5 Million Lifetime Benefit

After the **Deductible**, you pay a **Coinsurance amount**, up to an annual **Out-of-Pocket Expense Limit**. This **Expense Limit** helps control **most of** your annual out-of-pocket expenses for covered services, including deductible, copayments, and coinsurance. Covered drug expenses do not accumulate to the expense limit with KeyCare HealthSmart with Enhanced Drug Benefit.

In Network - Single or Family Coverage

Deductible	Coinsurance	Expense Limit
$ 2,250*	20%	$ 4,000
$ 3,500	20%	$ 5,000
$ 5,000	0%	$ 5,000
$ 7,500*	0%	$ 7,500
$10,000*	0%	$10,000

Out-of- Network

Deductible	Coinsurance	Expense Limit
$ 2,250	30%	$ 6,000
$ 3,500		$ 7,500
$ 5,000		$ 7,500
$ 7,500*		$11,500
$10,000*		$15,000

**Single policies with $7,500 or $10,000 deductibles are not compatible with Health Savings Accounts (HSAs). The family deductible option of $2,250 will no longer be HSA-compatible as of January 1, 2009.*

3 KeyCare HealthSmart℠ w/Enhanced Drug Benefit

$5 Million Lifetime Benefit

In Network and Out-of- Network

Offers the same policy deductible, coinsurance and expense limit options as KeyCare HealthSmart, but cannot be paired with a Health Savings Account (HSA) because drug benefits are paid before the deductible.

1 KeyCare® HSA

$5 Million Lifetime Benefit

Hospital Inpatient & Outpatient Care

In Network You Pay:
After deductible, 20% or 0%

Out-of-Network You Pay:
After sep. deductible, 30%

Emergency Care (after deductible)

You pay 20% or 0% coinsurance, in or out-of-network[1]

Doctor Visits

In Network You Pay:
After deductible, 20% or 0%

Out-of-Network You Pay:
After sep. deductible, 30%

Routine Wellness Care

In Network You Pay

Doctor Visits for Routine Wellness Care
After deductible you pay 20% or 0%
Two yearly visits per person.

Screenings
After deductible you pay 20% or 0%
Provides additional $150 yearly per person after deductible for routine lab, x-rays and immunizations.

Out-of-Network You Pay
After separate deductible 30% for doctor visits, screenings, routine lab, x-rays and immunizations.
Two yearly visits per person.
(combined with in-network visits)

Preventive Care and Immunizations for Children

Coverage same in or out-of-network.

In Network You Pay
Before deductible
0%

Out-of-Network You Pay
Same as in-network

Prescription Drugs

After deductible
40% or 0%

Yearly Benefit Maximum
$5,000 per person

For maximum benefits use network pharmacies and choose generic drugs when available.

[1]This applies if covered services are for emergency care as defined by Anthem.

Your Anthem Sales Representative has more details.

2 KeyCare HealthSmart℠

$5 Million Lifetime Benefit

Hospital Inpatient & Outpatient Care

In Network You Pay:
After deductible, 20% or 0%

Out-of-Network You Pay:
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Emergency Care (after deductible)

You pay 20% or 0% coinsurance, in or out-of-network[1]

Doctor Visits

In Network You Pay:
After deductible, 20% or 0%

Out-of-Network You Pay:
After sep. deductible, 30%

Routine Wellness Care

In Network You Pay

Doctor Visits for Routine Wellness Care
Before deductible you pay $20 for PCP; $30 for specialist
Unlimited visits per person.

Screenings
Before deductible you pay 20% for all screenings, routine lab, x-rays and immunizations.

Out-of-Network You Pay
After separate deductible 30% for doctor visits, screenings, routine lab, x-rays and immunizations.

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After sep. deductible, 30%

Emergency Care (after deductible)

You pay 20% or 0% coinsurance, in or out-of-network[1]

Doctor Visits

In Network You Pay:
After deductible, 20% or 0%

Out-of-Network You Pay:
After sep. deductible, 30%

Routine Wellness Care

In Network You Pay

Doctor Visits for Routine Wellness Care
Before deductible you pay $20 for PCP; $30 for specialist
Unlimited visits per person.

Screenings
Before deductible you pay 20% for all screenings, routine lab, x-rays and immunizations.

Out-of-Network You Pay
After separate deductible 30% for doctor visits, screenings, routine lab, x-rays and immunizations.

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Coverage same in or out-of-network.

In Network You Pay
Before deductible
0%

Out-of-Network You Pay
Same as in-network

Prescription Drugs

Before deductible
Non-specialty (Tier 1) drugs you pay: $15 or 40%, whichever is greater
Specialty (Tier 2) drugs: 40% up to $500 out-of-pocket maximum per prescription; $10,000 annual out-of-pocket maximum per person.

Yearly Benefit Maximum
$5,000 per person for non-specialty drugs only.

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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.

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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.

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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.

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.

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

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.

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.

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.
· skilled nursing facility stays	100 days
Prescription Drugs	
· Prescription Drugs	$5,000[2]
· Dispensed at Pharmacy	Up to a 34 day supply, or no more than 150 units per prescription, which ever is less.
· Ordered through WellPoint Next Rx Mail Service Pharmacy	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.

We also offer optional benefits at an additional cost. Ask your Anthem Representative for more details.

Important Information

This is not your policy and is intended as a brief summary of services. If there is any difference between this piece and the policy, the provisions of this policy shall control. This piece is only one part of your entire fulfillment kit. This piece refers to Policy Form #s 901119-CP.1 et al., Schedule of Benefits Form #s AVA1515 and PVA1721 and Application Form #s AVA1628, AVA1537, AVA1635 and optional coverage form #s AVA1393, AVA1517, 901167, and 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**.

Anthem®

Our service area is Virginia, excluding the city of Fairfax, the town of Vienna, and the area east of State Route 123.

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IMPORTANT CHANGES ABOUT HEALTH SAVINGS ACCOUNTS
PLEASE READ

2009 Annual Contribution Limits for Health Savings Accounts (HSAs)

About Health Savings Account Contributions
You are allowed to contribute up to the annual maximum amount as long as you are enrolled in an HSA-compatible high deductible health plan as of December 1st of the tax year and remain enrolled in the plan for 12 months. For 2009, the maximum annual contribution is $3,000 for self-only (single) policies and $5,950 for policies covering two or more people. These dollar limits may be adjusted for inflation each year for an annual cost-of-living increase.

To be considered HSA-compatible, a high deductible health plan (HDHP) must satisfy federal guidelines. In 2009, a HDHP is defined as a health plan:

- with an annual deductible that is not less than $1,150 for self-only coverage or $2,300 for family coverage; and
- the out-of-pocket expenses (deductible, copayments, and other amounts, but not premiums) do not exceed $5,800 for self-only coverage or $11,600 for family coverage.

How this Change Affects Individual KeyCare HealthSmart
Because of the new HSA contribution amounts set forth by the Internal Revenue Service for 2009, Anthem's Individual KeyCare HealthSmart "family" deductible option of $2,250 will no longer be HSA-compatible as of January 1, 2009.

If you are currently enrolled in an Individual KeyCare HealthSmart plan with a $2,250 family deductible, you may remain in the plan, if you choose. However, your high deductible plan is no longer HSA-compatible as of January 1, 2009, which means you will no longer be able to contribute to a Health Savings Account. If you would like to move to a higher deductible that is compatible with an HSA please call the Customer Service number located on the back of your Anthem identification card.

If you have questions or if your needs have changed, please contact your Anthem Blue Cross and Blue Shield Sales Representative or your Customer Care Advocate if you are currently enrolled in a KeyCare HealthSmart plan. The phone number is located on the back of your Anthem identification card.

This information is not tax or legal advice. The tax treatments vary for each situation. Please consult your tax and/or legal counsel for the tax implications of your unique situation. This refers to benefits outlined in Policy Form #901119-CP.1 et al., Schedule of Benefits Form #AVA1515 and Applications Forms #s AVA1628-AVA1633, AVA1537, AVA1635, Optional Coverage Form #s AVA1517, AVA1563 and AVA1393.

HS Mandate (10/2008)

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