Anthem
Health. **Join In.**

Individual and Family Health Care Plans
for **Virginia**

Plans designed to fit your plans

Premier
SmartSense℠
CoreShare℠

VABR0015544CSP (4/10)

Our plans help fit the way you live.

In a world that's constantly changing, one thing's for certain. You can benefit from the reliability and protection of health care coverage. Whether you're self-employed, need coverage for your family, just left group coverage, or your job doesn't provide it, Anthem Blue Cross and Blue Shield offers dependable individual health coverage plans that help save you time and make sense for the way you live.

You're in charge of your health and budget, and our plans help keep it that way. Check out our wide range of benefit options and if you have any questions, we are here to help. Dependable, valuable protection that may fit the way you live. Sounds like a plan.

Why do you need health care coverage?

These days, a single day in the hospital can cost thousands of dollars. The financial risk you take without health coverage just isn't worth it. Not only does health care coverage help you stay healthy, it also gives you added security, because you know you have help to protect against the high cost of unexpected medical bills.

Experience you can rely on

As one of the most trusted names in health coverage, Anthem has been providing health care coverage and security to Virginia for nearly 75 years. We're committed to helping simplify your life and improving your health. In addition, we offer:

- **One of the largest provider networks in Virginia.** With more than 16,900 PPO doctors and specialists* and nearly 100 hospitals throughout Virginia*, chances are your doctor is in our network. For a complete listing of all doctors in our network, go to anthem.com and click on "Find a Doctor".
- **A choice of plans to fit many budgets and lifestyles.** No matter where you are in life, we've got a plan designed to fit a variety of health coverage needs, as well as many budgets.
- **Optional dental and life insurance.** To enhance your health, we also offer dental and term life coverage and make it easy to enroll.
- **Coverage that travels with you.** No matter where life takes you, your health coverage goes with you. Network providers in the BlueCard® program across the country will help make it easy to get access to the care you need when on a short trip or vacation.

*Anthem Blue Cross and Blue Shield Capabilities Fact Sheet, 10/09

Some definitions so we're all on the same page

Network Discounts: With Anthem, you have access to one of the largest provider networks in the state. These network (or participating) providers have agreed to accept lower costs for their covered services to Anthem members — similar to volume discounts. These negotiated costs help reduce the overall cost of covered medical services, including your share of those costs.

This is true whether you are paying the entire cost for covered services (such as while you are meeting your deductible), or whether we are sharing the cost. With over 16,900 practitioners and nearly 100 hospitals*, chances are your provider already participates. Just visit a network provider to take advantage of the savings.

With our PPO plans, you can always choose to receive services outside the network, but your share of the cost will be greater.

Cost–Sharing: The costs of medical care today can be staggering. Health care coverage from Anthem can help protect you against these high costs. With most health care coverage, you pay a monthly premium, then you share some of the cost of covered medical care with the company that provides your health care coverage. The level of cost-sharing you choose directly impacts your premium amount. The more you are willing to share in the cost, the lower your premium. With Anthem, you can choose your level of protection and the level of cost-sharing that works best for your health care needs and budget.

Deductible is the amount you have to pay each calendar year for covered services before your health care plan starts paying. For some services, the plan will even begin to pay before the deductible is met. Usually, the higher a plan's deductible, the lower the premium. In some cases, you may also have a separate deductible for certain services such as prescription drugs.

Coinsurance is the percentage of the cost of covered services that you will be responsible for, after your annual deductible is met. With some plans, you have a choice of coinsurance levels. Much like your deductible, selecting a higher coinsurance typically lowers your monthly premium because it increases your share of the cost.

Copayment is a specific dollar amount you have to pay for certain covered services.

Out-Of-Pocket Maximum is the most that you would pay in a calendar year for deductible and coinsurance for in-network covered services. Once you reach this maximum, the plan pays at 100% for most network services for the rest of the calendar year. There is a separate out-of-pocket maximum for non-network services.

Lifetime Maximum is the lifetime benefit amount that will be paid under the policy for each member. This includes network and non-network covered services combined.

Prescription Drugs are medications that must be authorized for use by your doctor. Anthem offers varying levels of prescription drug coverage. Depending on the plan, you may have coverage for generic drugs or generic and brand name drugs.

Generic Drugs are prescription drugs that typically have been in use for some time and can be manufactured and distributed by numerous companies, so their cost is usually much lower. Generic drugs must, by law, contain the same active ingredients as their brand name equivalent and have the same clinical benefit.

Brand Name Drugs are prescription drugs that are manufactured and marketed under a registered name. They are usually patented and may be exclusively offered by certain manufacturers.

Formulary is a list of prescription drugs our health care plans cover. They may include generic, preferred brand name and specialty drugs that have been rigorously reviewed and selected by a committee of practicing doctors and clinical pharmacists for their quality and effectiveness. We've negotiated lower prices on these formulary drugs, so you'll save when your doctor prescribes medication from our formularies. There can be different formularies for different health care plans. Formulary lists can be found at www.wellpointnextrx.com/formulary1.

*Anthem Blue Cross and Blue Shield Capabilities Fact Sheet, 10/09

Premier Is this the right plan for you?

Premier health care plans offer the highest level of benefits we offer for a variety of services. Great for families or for individuals looking for richer benefits, Premier provides a number of benefits before the deductible, and strong coverage for Preventive Care and Prescription Drugs.

Premier Plan Highlights

Premier offers robust benefits for both routine and unexpected medical care. Compared to our other plans, Premier has lower coinsurance levels across all deductibles offered. This added value helps lower your share of the cost once you satisfy your deductible.

Features:

- Premier offers benefit options including an unlimited number of doctors' office visits, with predictable copayment, before the deductible.
- Annual vision screening exam with copayment.
- $5 million per member in lifetime benefits.
- Preventive Care benefits that focus on keeping you well.

You should know:

- Maternity benefits are available with deductible options of $2,500 and higher, for an additional cost.
- Premier has our highest level of benefits available, so the premiums are typically more than our other plans.

Premier Preventive Care

Preventive care is an important component of Premier plan coverage. You receive many covered preventive services before the deductible, including childhood immunizations, mammograms, Pap and PSA tests and more! See your Benefit Guide for more details.

Prescription Drug Coverage

Premier offers broad prescription drug coverage before the deductible, including benefits for generic, brand name and specialty drugs

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 the cost between brand and generic, plus your copayment or coinsurance.

See your Benefit Guide for more details.

How to Customize your Premier Plan

With Premier, you have choice and flexibility to change the plan to better meet your needs. Premier offers a choice of:

Deductible: Premier deductibles range from $500 to $10,000. You can usually lower your premium by choosing a higher deductible. Simply choose the deductible and premium combination that works best for you.

Coinsurance: Premier offers a choice of coinsurance options, including one with no coinsurance at all for most care, depending on the deductible you choose. The zero coinsurance options are typically with the higher deductibles, which can lower your premium in most cases.

Dental Coverage, Maternity, Supplemental Accident and Life Insurance: Add these options to complete your protection for yourself or your family. See your Benefit Guide and the dental and life information in the back of this brochure for more details.

Benefits	Premier						
Calendar Year Deductible	**Your Choices**						
Individual — NETWORK:	$500	$1,500	$2,500	$3,500	$5,000	$7,500	$10,000
Individual — NON-NETWORK:	$500	$1,500	$2,500	$3,500	$5,000	$7,500	$10,000
Family — NETWORK:	$1,000	$3,000	$5,000	$7,000	$10,000	$15,000	$20,000
Family — NON-NETWORK:	$1,000	$3,000	$5,000	$7,000	$10,000	$15,000	$20,000
Network Coinsurance Options	20%*	20%*	20%* or 0%*	0%*	0%*	0%*	0%*
Calendar Year Out-of-Pocket Maximum	**Add Your Chosen Deductible to the Amount Below**						
Individual — NETWORK:	$2,000	$2,000	$2,000 or $0	$0	$0	$0	$0
Individual — NON-NETWORK:	$7,500	$7,500	$7,500	$7,500	$7,500	$7,500	$7,500
Family — NETWORK:	$4,000	$4,000	$4,000 or $0	$0	$0	$0	$0
Family — NON-NETWORK:	$15,000	$15,000	$15,000	$15,000	$15,000	$15,000	$15,000
How family deductibles and family out-of-pocket maximums work	For family plans (with two or more members) any combination of family members can meet or contribute toward the family deductible or family out-of-pocket maximum. However, no individual member can contribute more than their individual deductible or out-of-pocket maximum.						
Plan Lifetime Maximum	Plan pays up to: $5 million per member, network and non-network services combined						

Covered Services	Your Share of Costs (after deductible, unless waived)
Doctors' Office Visits	**NETWORK (deductible waived):** **$30 Copay** for primary care physician; **$40 Copay** for specialist. **NON-NETWORK** **30% Coinsurance**
Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.)	**NETWORK:** **20% or 0% Coinsurance**[1] **NON-NETWORK:** **30% Coinsurance**
Inpatient Services (overnight hospital/facility stays)	**NETWORK:** **20% or 0% Coinsurance**[1] **NON-NETWORK:** **30% Coinsurance**
Outpatient Services (without overnight hospital/facility stays)	**NETWORK:** **20% or 0% Coinsurance**[1] **NON-NETWORK:** **30% Coinsurance**
Emergency Room Services	**NETWORK:** **20% or 0% Coinsurance**[1] **NON-NETWORK:** **20% or 0% Coinsurance**[1]
Preventive Care Services	**Adults and Children age 7 and older:** **NETWORK (deductible waived):** · **Preventive Office Visits (unlimited):** **$30 Copay** for primary care physician; **$40 Copay** for specialist. · **Preventive Screenings and Lab, X-rays and Immunizations:** **20% or 0% Coinsurance**[1,2] **NON-NETWORK:** **30% Coinsurance** **Preventive Care and Immunizations for Children age 6 and under:** Includes coverage for office visits, lab tests, vision and hearing screenings and immunizations. **NETWORK or NON-NETWORK:** **0% Coinsurance** (copy and deductible waived)
Maternity	Not Covered (see Optional Coverage below)
Optional Coverage (at additional cost)	Dental, Life, Maternity (available with $2,500 deductible or greater) and Supplemental Accident Coverage

Prescription Drug Coverage	Premier
Retail Drugs (and Mail Order Drugs when available)	**NETWORK (deductible waived):** · **Generic and Brand Name Drugs:** **$15 Copay or 40% Coinsurance,** whichever is greater. $7,500 annual benefit maximum per member (not including Specialty drugs), network and non-network combined. · **Specialty Drugs:** **40% Coinsurance,** up to a separate $10,000 annual Prescription Drug out-of-pocket maximum per member. **NON-NETWORK (deductible waived):** Same benefit as network, however, member is responsible for filing the claim and for the difference between the pharmacy charge and our allowable charge, plus applicable copay or coinsurance.
Optional Drug Coverage (when available)	Not applicable; Premier already includes upgraded drug coverage.
Other Covered Benefits include but are not limited to:	Ambulance, Chiropractic Care, Durable Medical Equipment, Home Health and Hospice Care, Mental Health, Physical/Occupational Therapy, Substance Abuse, Speech Therapy, Urgent Care, Routine Vision Exam

IMPORTANT: This Benefit Guide is intended to be a brief outline of coverage and is not intended to be a legal contract. The entire provisions of benefits, limitations and exclusions are contained in the Contract/Certificate. In the event of a conflict between the Contract/Certificate and this Benefit Guide, the terms of the Contract/Certificate will prevail.

[1] Coinsurance is designated by the deductible you choose. If the network coinsurance is 20%, the non-network coinsurance is 30%. If the network coinsurance is 0%, the non-network coinsurance is 30%, unless specified otherwise.

[2] The 0% coinsurance is for routine mammograms and colorectal cancer screenings when a 0% coinsurance plan is chosen.

*Your coinsurance will be higher with a non-network provider.

NOTE: Network and non-network deductibles are separate and do not accumulate toward each other. Network and non-network out-of-pocket maximums are separate and do not accumulate toward each other.

SmartSense℠ Is this the right plan for you?

SmartSense was designed to offer affordable, solid protection without a lot of bells and whistles that may not be important to you.

SmartSense Plan Highlights

SmartSense offers affordable price options, solid protection that covers many essentials, and even some immediate benefits before the deductible.

Features:

- Immediate coverage for the first three doctors' office visits with predictable copayment. This includes routine wellness visits or sick care. After the first three visits, doctor visits are covered after the deductible.
- Choice of prescription drug coverage options.
- $3 million per member in lifetime benefits.

You should know:

- Maternity benefits are not available with this plan.
- After the first three Doctors' Office Visits, all other visits apply toward your deductible.
- Generic and select brand name drugs are also available before the deductible, with a copayment or coinsurance.

SmartSense Preventive Care

SmartSense offers basic preventive coverage, including services such as childhood immunizations, PSA and Pap tests, colorectal cancer screenings, and mammograms.

Prescription Drug Coverage

SmartSense includes coverage for generic and select brand name and specialty drugs.

For an additional cost, you can upgrade the SmartSense prescription benefit to extend the coverage for brand name and specialty drugs.

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 on the formulary, when a generic drug is available, you will be responsible for the difference in the cost between brand and generic, plus your copayment or coinsurance.

See your Benefit Guide for more details.

How to Customize your SmartSense Plan

With SmartSense, you have some choice and flexibility to change the plan to better meet your needs. SmartSense offers a choice of:

Deductible: SmartSense deductibles range from $750 to $10,000. You can usually lower your premium by choosing a higher deductible. Simply choose the deductible and premium combination that works best for you.

Coinsurance: SmartSense offers a choice of coinsurance levels depending on the deductible you choose. Choosing a higher deductible can take your coinsurance for covered services to zero if you'd like to pay more toward your calendar year deductible first.

Prescription Drug Benefit: You can customize your plan by selecting the Optional Enhanced Prescription Drug coverage, as described on your Benefit Guide.

Dental Coverage, Supplemental Accident and Life Insurance: Add these options to complete your protection for yourself or your family. See your Benefit Guide and the dental and life information in the back of this brochure for more details.

Benefits	SmartSense℠						
Calendar Year Deductible	**Your Choices**						
Individual — NETWORK:	$750	$1,500	$2,500	$3,500	$5,000	$7,500	$10,000
Individual — NON-NETWORK:	$750	$1,500	$2,500	$3,500	$5,000	$7,500	$10,000
Family — NETWORK:	$1,500	$3,000	$5,000	$7,000	$10,000	$15,000	$20,000
Family — NON-NETWORK:	$1,500	$3,000	$5,000	$7,000	$10,000	$15,000	$20,000
Network Coinsurance Options	30%*	30%*	30%*	30%*	30%*	30%*	0%*
Calendar Year Out-of-Pocket Maximum	**Add Your Chosen Deductible to the Amount Below**						
Individual — NETWORK:	$3,500	$3,500	$3,500	$3,500	$3,500	$3,500	$0
Individual — NON-NETWORK:	$7,500	$7,500	$7,500	$7,500	$7,500	$7,500	$7,500
Family — NETWORK:	$7,000	$7,000	$7,000	$7,000	$7,000	$7,000	$0
Family — NON-NETWORK:	$15,000	$15,000	$15,000	$15,000	$15,000	$15,000	$15,000
How family deductibles and family out-of-pocket maximums work	For family plans (with two or more members) any combination of family members can meet or contribute toward the family deductible or family out-of-pocket maximum. However, no individual member can contribute more than their individual deductible or out-of-pocket maximum.						
Plan Lifetime Maximum	Plan pays up to: $3 million per member, network and non-network services combined						

Covered Services	Your Share of Costs (after deductible, unless waived)
Doctors' Office Visits	**NETWORK:** · **Office Visit Copay for first 3 yearly visits:** **$35 Copay,** deductible waived, for primary care physician or specialist visits. · **Office Visit Coinsurance for remaining visits:** **30% or 0% Coinsurance**[1] **NON-NETWORK:** **50% or 30% Coinsurance**[1]
Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.)	**NETWORK:** **30% or 0% Coinsurance**[1] **NON-NETWORK** **50% or 30% Coinsurance**[1]
Inpatient Services (overnight hospital/facility stays)	**NETWORK:** **30% or 0% Coinsurance**[1] **NON-NETWORK:** **50% or 30% Coinsurance**[1]
Outpatient Services (without overnight hospital/facility stays)	**NETWORK:** **30% or 0% Coinsurance**[1] **NON-NETWORK:** **50% or 30% Coinsurance**[1]
Emergency Room Services	**NETWORK:** **30% or 0% Coinsurance**[1] **NON-NETWORK:** **30% or 0% Coinsurance**[1]
Preventive Care Services	**Adults and Children age 7 and older:** **NETWORK:** **Preventive Office Visits:** Two yearly visits per person. If included with first 3 yearly doctor visits, you pay **$35** (deductible waived). If after first 3 yearly doctor visits, **30% or 0% Coinsurance** after deductible. **Preventive Screenings:** **30% or 0% Coinsurance**[1] **NON-NETWORK:** **50% or 30% Coinsurance**[1] **Preventive Care and Immunizations for Children age 6 and under:** Includes coverage for office visits, lab tests, vision and hearing screenings and immunizations. **NETWORK or NON-NETWORK:** **0% Coinsurance** (copay and deductible waived)
Maternity	Not Covered
Optional Coverage (at additional cost)	Dental, Life, and Supplemental Accident Coverage

Prescription Drug Coverage	SmartSense
Retail Drugs (and Mail Order Drugs when available)	**Standard Drug Coverage (deductible waived):** **NETWORK:** · **For Drugs on Formulary (Generic and Brand Name/Specialty Drugs):** **$15 Copay or 40% Coinsurance,** whichever is greater. $7,500 annual benefit maximum per member (not including Specialty drugs), network and non-network combined. · **For Drugs Not on Formulary:** Not covered[2] **NON-NETWORK:** Same benefit as network, however, member is responsible for filing the claim and for the difference between the pharmacy charge and our allowable charge plus applicable copay or coinsurance.
Optional Drug Coverage (when available)	**Upgrade Drug Coverage (deductible waived):** **NETWORK:** · **For Generic and Brand Name Drugs:** **$15 Copay or 40% Coinsurance,** whichever is greater. $7,500 annual benefit maximum per member (not including Specialty drugs), network and non-network combined. · **For Specialty Drugs:** **40% Coinsurance** up to a separate $10,000 annual Prescription Drug out-of-pocket maximum per member. **NON-NETWORK:** Same benefits as network, however, member is responsible for filing the claim and for the difference between the pharmacy charge and our allowable charge plus applicable copay or coinsurance.
Other Covered Benefits include but are not limited to:	Ambulance, Chiropractic Care, Durable Medical Equipment, Home Health and Hospice Care, Mental Health, Physical/Occupational Therapy, Substance Abuse, Speech Therapy, Urgent Care

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[1] Coinsurance is designated by the deductible you choose. If the network coinsurance is 30%, the non-network coinsurance is 50%. If the network coinsurance is 0%, the non-network coinsurance is 30%.

[2] Not covered except as specifically provided for and described in the policy.

*Your coinsurance will be higher with a non-network provider.

NOTE: Network and non-network deductibles are separate and do not accumulate toward each other. Network and non-network out-of-pocket maximums are separate and do not accumulate toward each other.

CoreShare℠ Is this the right plan for you?

CoreShare is one of our lowest cost plans and offers a simple plan design. When considering CoreShare, please note that your share of the cost for covered services is typically higher than with our other plans — this cost-sharing helps lower your monthly premium. The overall premium savings work well if you are looking for help against unforeseen medical costs.

CoreShare Plan Highlights

CoreShare health care plan can be ideal for individuals who are comfortable handling day-to-day medical expenses, and are primarily looking for some protection from the unexpected.

Features:

- A wide array of covered services including doctors' office visits, hospital, surgical, and outpatient care.
- Access to Anthem's discounts for covered health care services. These discounts lower your cost whether you are satisfying your deductible or sharing the cost with us.
- A dependable out-of-pocket maximum amount, so you'll know the most you'll be responsible for in a calendar year. Once you reach this limit, your covered services are usually paid at 100% for the remainder of that year. For more information, see the Definitions page.
- $2 million per member in lifetime benefits.

You should know:

- Maternity benefits are not available with this plan and cannot be added to this plan for an additional cost.
- Your coinsurance for most services is 50%, unless you choose one of the higher deductibles.

CoreShare Preventive Care

CoreShare offers basic preventive coverage, including services such as childhood immunizations, PSA and Pap tests, colorectal cancer screenings and mammograms.

Prescription Drug Coverage

CoreShare includes coverage for generic, brand name and specialty drugs that are included on our formulary. For generic drugs, you pay a copayment or coinsurance depending on the cost of the drug. For covered brand name and specialty drugs, you will have a separate prescription drug deductible and then you pay your copayment or coinsurance. Prescription drugs that are not included on the formulary are not covered.

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 on the formulary when a generic drug is available, you will be responsible for the difference in the cost between brand and generic, plus your copayment or coinsurance.

See your Benefit Guide for more details.

How to Customize your CoreShare Plan

With CoreShare, you have some choice and flexibility to change the plan to better meet your needs. CoreShare offers a choice of:

Deductible: CoreShare deductibles range from $750 to $25,000. You can usually lower your premium by choosing a higher deductible. Simply choose the deductible and premium combination that works best for you.

Coinsurance: CoreShare offers a choice of coinsurance levels depending on the deductible you choose. Choosing a higher deductible can take your coinsurance for covered services to zero if you'd like to pay more toward your calendar year deductible first.

Facility Copayment: Similar to the coinsurance percentage, if you choose a $10,000 or higher deductible, you can eliminate the facility copayment requirement, and you will only be responsible for any deductible or coinsurance. Otherwise, there is a copayment that will apply for inpatient hospital stays or outpatient surgeries.

Benefits	CoreShare℠								
Calendar Year Deductible	**Your Choices**								
Individual — NETWORK:	$750	$1,500	$2,500	$3,500	$5,000	$7,500	$10,000	$15,000	$25,000
Individual — NON-NETWORK:	$750	$1,500	$2,500	$3,500	$5,000	$7,500	$10,000	$15,000	$25,000
Family — NETWORK:	$1,500	$3,000	$5,000	$7,000	$10,000	$15,000	$20,000	$30,000	$50,000
Family — NON-NETWORK:	$1,500	$3,000	$5,000	$7,000	$10,000	$15,000	$20,000	$30,000	$50,000
Network Coinsurance Options	50%*	50%*	50%*	50%*	50%*	50%*	0%*	0%*	0%*
Calendar Year Out-of-Pocket Maximum	**Add Your Chosen Deductible to the Amount Below**								
Individual — NETWORK:	$3,500	$3,500	$3,500	$3,500	$3,500	$3,500	$0	$0	$0
Individual — NON-NETWORK:	$7,500	$7,500	$7,500	$7,500	$7,500	$7,500	$7,500	$7,500	$7,500
Family — NETWORK:	$7,000	$7,000	$7,000	$7,000	$7,000	$7,000	$0	$0	$0
Family — NON-NETWORK:	$15,000	$15,000	$15,000	$15,000	$15,000	$15,000	$15,000	$15,000	$15,000
How family deductibles and family out-of-pocket maximums work	For family plans (with two or more members) any combination of family members can meet or contribute toward the family deductible or family out-of-pocket maximum. However, no individual member can contribute more than their individual deductible or out-of-pocket maximum.								
Plan Lifetime Maximum	Plan pays up to: $2 million per member, network and non-network services combined								

Covered Services	Your Share of Costs (after deductible, unless waived)
Doctors' Office Visits	**NETWORK:** **50% or 0% Coinsurance**[1] **NON-NETWORK:** **70% or 50% Coinsurance**[1]
Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.)	**NETWORK:** **50% or 0% Coinsurance**[1] **NON-NETWORK:** **70% or 50% Coinsurance**[1]
Inpatient Services (overnight hospital/facility stays)	**NETWORK:** **$750 Inpatient Facility Copay**[2], then deductible plus **50% Coinsurance** per admission (with $750, $1,500, $2,500, $3,500, $5,000, $7,500 plans); **0% Coinsurance** (with $10,000, $15,000, $25,000 plans) **NON-NETWORK:** **$750 Inpatient Facility Copay**[2], then deductible plus **70% Coinsurance** per admission (with $750, $1,500, $2,500, $3,500, $5,000, $7,500 plans); **50% Coinsurance** (with $10,000, $15,000, $25,000 plans)
Outpatient Services (without overnight hospital/facility stays)	**NETWORK:** **$200 Outpatient Facility Surgical Procedure Copay**[2], then deductible plus **50% Coinsurance** per procedure (with $750, $1,500, $2,500, $3,500, $5,000, $7,500 plans); **0% Coinsurance** (with $10,000, $15,000, $25,000 plans) **NON-NETWORK:** **$200 Outpatient Facility Surgical Procedure Copay**[2], then deductible plus **70% Coinsurance** per procedure (with $750, $1,500, $2,500, $3,500, $5,000, $7,500 plans); **50% Coinsurance** (with $10,000, $15,000, $25,000 plans)
Emergency Room Services	**NETWORK:** **50% or 0% Coinsurance**[1] **NON-NETWORK:** **50% or 0% Coinsurance**[1]
Preventive Care Services	**Adults and children age 7 and older:** **NETWORK:** **Preventive Office Visits:** Two yearly visits per person, **50% or 0% Coinsurance**[1] **Preventive Screenings:** **50% or 0% Coinsurance**[1] **NON-NETWORK:** **70% or 50% Coinsurance**[1] **Preventive Care and Immunizations for Children age 6 and under:** Includes coverage for office visits, lab tests, vision and hearing screenings and immunizations. **NETWORK or NON-NETWORK:** **0% Coinsurance** (deductible waived)
Maternity	Not Covered
Optional Coverage (at additional cost)	Dental, Life, and Supplemental Accident Coverage

Prescription Drug Coverage	CoreShare
Retail Drugs (and Mail Order Drugs when available)	**NETWORK:** · **For Drugs on Formulary (Generic and Brand Name/Specialty Drugs):** **$15 Copay or 50% Coinsurance,** whichever is greater. $1,000 annual deductible per member on Brand/Specialty drugs. $5,000 annual benefit maximum per member (not including Specialty drugs), network and non-network combined. · **For Drugs Not on Formulary:** Not covered[3] **NON-NETWORK:** Same benefit as network, however, member is responsible for filing the claim and for the difference between the pharmacy charge and our allowable charge, plus applicable copay or coinsurance.
Optional Drug Coverage (when available)	Not Available
Other Covered Benefits include but are not limited to:	Ambulance, Chiropractic Care, Durable Medical Equipment, Home Health and Hospice Care, Mental Health, Physical/Occupational Therapy, Substance Abuse, Speech Therapy, Urgent Care

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[1] Coinsurance is designated by the deductible you choose. If the network coinsurance is 50%, the non-network coinsurance is 70%. If the network coinsurance is 0%, the non-network coinsurance is 50%.

[2] Balance of charges subject to deductible and coinsurance. The Inpatient Facility Copay and Outpatient Facility Surgical Procedure Copay does not accumulate toward the deductible or out-of-pocket maximum. Facility Copay is still required even if out-of-pocket maximum has been met.

[3] Not covered except as specifically provided for and described in the policy.

*Your coinsurance will be higher with a non-network provider.

NOTE: Network and non-network deductibles are separate and do not accumulate toward each other. Network and non-network out-of-pocket maximums are separate and do not accumulate toward each other.

Dental Coverage

Dental coverage is important to your overall health and well-being. Regular dental check-ups can serve as an early warning for health-related issues. In fact, gum and tooth disease have been linked to a number of major health conditions like heart disease, stroke, respiratory disease and diabetes. Who knew seeing a dentist may help save your life?

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

Protect your smile — and your health — by adding optional dental coverage to your plan.

Preventive Care

Covered Services	Waiting Period	Coinsurance		Deductible		Maximum Covered Per Year
		NETWORK	NON-NETWORK	NETWORK	NON-NETWORK	
Diagnostic (2 oral exams)	None	0%	50%	None	None	$1,000 per covered person for preventive, restorative and complex care
X-Rays (1 set of bitewings per year. 1 full mouth series every 3 years covered persons age 5 and over)	None	0%	50%	None	None	
Preventive (includes cleanings, topical fluoride treatments for children under 16, space maintainers for children under 12)	None	0%	50%	None	None	

Restorative and Complex Care

Covered Services	Waiting Period	Coinsurance		Deductible		Maximum Covered Per Year
		NETWORK	NON-NETWORK	NETWORK	NON-NETWORK	
Restorative Services (fillings)	6 Months	50%	50%	$50/ Individual up to $150/ family	$100/Individual up to $300/ family	$1,000 per covered person for preventive, restorative and complex care
Simple Extractions						
Anesthesia (emergency treatment of dental pain for minor procedures, general anesthesia with oral surgery)						
Oral Surgery (includes root removal, treatment of abcess)	18 Months					
Prosthodontic Services (includes onlays, crowns, dentures)						
Endodontic Services (root canals)						
Periodontal Services (includes periodontal cleaning, scaling, and root planing)						

Blue Preferred Term Life™

Losing a loved one is painful enough without having to worry about finances. So why not give your family the extra support they'll need with term life insurance from Anthem Life.

- **It's inexpensive.** Just pennies a day.
- **It's easy.** Simply complete the term life section on your application.

Be prepared for the unexpected.

Life happens! But sadly, so can an unexpected death. Help secure your family's future by considering the following coverage options:

- $25,000 coverage for yourself and $25,000 for your spouse, and $15,000 coverage for dependent child(ren)
- $50,000 coverage for yourself and $50,000 for your spouse, and $15,000 coverage for dependent child(ren)

Blue Preferred Term Life
Monthly premiums are per person and subject to change.

Age	$25,000	$50,000	$15,000 for dependent children only
1-18	$2.50	$5.00	$1.50
19-29	$4.75	$9.50	$2.85
30-39	$5.50	$11.00	$3.30
40-49	$12.50	$25.00	$7.50
50-59	$34.75	$69.50	$20.85
60-64	$49.00	$98.00	$29.40
65+	Not Available		

1. Children less than one year of age and who qualify medically will be automatically added to the policy on the policy anniversary after they turn one.
2. The $15,000 policy is available to dependent children only, with a maximum of three dependent children. More than three children can be added to the plan, but no additional premium will be charged.
3. Spouses or domestic partners are not eligible for the $15,000 dependent coverage and must select the same plan as the subscriber if applying together. For domestic partner coverage on the same application, two separate policies will be issued.
   Note: Acceptance into an Anthem Life policy is contingent upon your acceptance into an Anthem underwritten health plan.

Supplemental Accident Coverage

All our plans provide emergency care benefits, but the unexpected costs of an accident can still add up. With each plan, you can purchase Supplemental Accident coverage to help you with these costs. With this coverage, Anthem would pay 100% of the allowable charge, up to a total of $750 per person, per year. In order to make the most of these benefits, you'll still need to visit a network provider, or your share of the costs for covered services may increase.

Maternity

If you're hoping to add to your family in the future, you may want to think about adding maternity coverage now. An optional maternity coverage is available with certain plans (see your Benefit Guide for details) to help cover pregnancy and childbirth related medical care for mother and infant.

There are specific limitations and exclusions for this coverage, including a waiting period in most cases before conception can occur; see your Coverage Details insert for this important information.

Ready to choose a plan?

- **Call us.** Contact your Anthem Blue Cross and Blue Shield Sales Representative or Agent.
- **Ask questions.** If you aren't sure about how a plan works or have additional questions, your sales agent will be happy to help.
- **Fill out an application.** We'll process it as soon as we receive it. We'll let you know if you are approved for the plan you selected, or any other coverage options you may have.

Anthem
Health. **Join In.**

Individual and Family Health Care Plans
for **Virginia**

Individual health coverage. Your plans. Your choices.

Make sure you have all the facts.

This brochure is only one piece of your plan information. Please make sure you have all the facts about the benefits offered by the plans described – including what's covered, and what isn't. For additional information about exclusions, limitations, and terms of this coverage, please see the enclosed Coverage Details and Benefit Guide. These documents should be included with your information kit, or if you have printed this from your computer, they should be at the end of this document. If you don't have these documents, be sure to contact your Anthem sales agent.

This brochure is intended as a brief summary of benefits and services; it is not your Contract/Certificate. If there is any difference between this brochure and your Contract/Certificate, the provisions of the Contract/Certificate will prevail. Benefits and premiums are subject to change.

"No Obligation" review period.

After you enroll in a plan offered by Anthem, you will receive a contract booklet that explains the exact terms and conditions of coverage, including the plan's exclusions and limitations. You will have 10 days to examine your plan's features. During that time, if you are not fully satisfied, you may decline by returning your contract booklet along with a letter notifying us that you wish to discontinue coverage.

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 forms 06714VAMEN, 06716VAMEN and 06718VAMEN, application forms MVAFR6672A - MVAFR6674A and optional rider forms AVA1563, AVA1393 and AVA1517.

Ready to enroll?

Call your Anthem Sales Representative or agent today!

For internal use only:
VA01 BR (4/10)

75 YEARS STRONG
ANTHEM BLUE CROSS AND BLUE SHIELD

Coverage Details Things you need to know before you buy...

Anthem
Health. **Join In.**

Premier, SmartSense,® SmartSense® with Enhanced Drug Benefit, CoreShare,℠ Lumenos® HSA, Lumenos® HIA, KeyCare HealthSmart℠ with Enhanced Drug Benefit, Flexible Choice,℠ Essential KeyCare® and KeyCare Preferred®

Listed below are specific requirements and procedures for our plans that provide information you need to know when choosing a health care plan as well as after you have coverage. This document is included to help you understand how our Premier, SmartSense,® SmartSense® with Enhanced Drug Benefit, CoreShare,℠ Lumenos® HSA, Lumenos® HIA, KeyCare HealthSmart℠ with Enhanced Drug Benefit, Flexible Choice,℠ Essential KeyCare® and KeyCare Preferred® plans work. Please review these Coverage Details along with the other materials enclosed.

Policy Terms

The following are provisions to our policies, which outline specific requirements and procedures about our plans. However, keep in mind that this document is not your official policy. You must apply for and be accepted for enrollment before a policy for health care coverage is issued to you. 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 or Lumenos service area*
- Qualify medically and meet certain lifestyle 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
- Are not on active duty with any branch of the Armed Services

Eligible children must also be:

- Unmarried
- Under age 23

Your domestic partner, if applicable, is only eligible for coverage if he or she:

- Has been your sole domestic partner for 6 months or more
- Is mentally competent
- Is at least 18 years old
- Is not related to you in any way (including by blood or adoption) that would prohibit you from being married to or separated from anyone else and
- Is financially interdependent with you

Employees covered by Anthem Blue Cross and Blue Shield group insurance are not eligible to purchase an Anthem individual policy until they have been off the group coverage at least 64 days. Employees may not apply for an Anthem individual policy with an effective date that is less than 64 days after their Anthem group coverage ended. However, spouses, domestic partners and dependents may be eligible to apply for Anthem individual coverage without having to wait 64 days.

** 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 and Lumenos service area if applying for any of the plans listed above).*

Policy Effective Date

1. Your policy effective date must be within 75 days (120 days for Virginia Standard or Lumenos Standard HSA policies) of the the date you signed the application.
2. The earliest effective date you can have if you currently have coverage would be the day after the application is received by Anthem through mail, fax or online submission. This applies if you requests an 'As Soon As Possible' effective date as well.
3. The earliest effective date you can have if you currently do not have health care coverage would be 10 days after your application is received by Anthem through mail, fax or online submission. This applies if you request an 'As Soon As Possible' effective date as well.
4. The earliest effective date for children less than 6 months of age is the day of approval by Anthem. This does not apply to newborns being added to an existing policy within first 31 days.

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
- 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 document 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.

Premium With Application

Beginning November 1, 2009, Anthem Blue Cross and Blue Shield requires the first premium payment with each application for Individual health care plans. Personal checks will not be deposited until the application is approved. If you are not accepted for coverage, we will notify you in writing. We destroy all personal checks received related to applications where coverage cannot be issued. Money orders and cashier's checks will be deposited prior to underwriting, and if the application is denied, a refund will be issued.

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.

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
- 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
- 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

All of the plans referenced in this document 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 a non-network provider.

What's Not Covered

Exclusions:

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

Our 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 document 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

These plans only cover preventive care specified in the plan's 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 That Are 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 practices 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 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. We do not cover family planning services including services for or related to artificial insemination or in vitro fertilization or any other types of artificial or surgical means of conception; prescription drugs prescribed in conjunction with artificial insemination or any other types of artificial or surgical means of conception. We do not cover any services or supplies provided to a person not covered under the policy in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple); or services to reverse voluntarily induced sterility.

Dental Services

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

Hearing Services

Hearing services, except as specifically provided for in the policy. 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

Routine vision services except as specifically provided for in the policy. 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, farsightedness, 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.

Health Club Memberships

Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a physician. This also applies to health spas.

Weight Loss Programs

Weight loss programs, whether or not they are pursued under medical or physician supervision, unless specifically listed as covered in the policy. This includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs. This does not apply to medically necessary treatments for morbid obesity as required by law.

Nutritional And/Or Dietary Supplements

Nutritional and/or dietary supplements, except as provided in the policy or as required by law. This includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist.

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
- Prescription drugs not approved by the FDA
- Prescription drugs not found on Anthem's Formulary for SmartSense and CoreShare are not covered
- Brand name drugs for Essential KeyCare are not covered

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 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
- Manual medical interventions for illnesses or injuries other than musculoskeletal illnesses or injuries

Out-Of-Pocket Maximum Exclusions

The following items never count toward your out-of-pocket maximum for all products:

- Amounts exceeding the allowable charge
- Amounts over any policy maximum or limitation
- Expenses for services not covered under the policy

In addition, specific products have additional items that never count toward your out-of-pocket maximum:

Premier, SmartSense, SmartSense with Enhanced Drug Benefit, and CoreShare:

- Amounts paid for prescription drugs, including specialty drugs and insulin
- Copayments
- Copayments and coinsurance (if applicable) for routine vision care

KeyCare Flexible Choice and KeyCare HealthSmart with Enhanced Drug Benefit:

- Amounts paid for prescription drugs, including specialty drugs and insulin

KeyCare Preferred and Essential KeyCare:

- Amounts we apply to your deductible
- Any Coinsurance Limitations listed in the "Coinsurance Limitations" section of this document
- Copayments

Optional Coverage Exclusions

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

Dental Coverage Exclusions

Our policies do not cover:

- Services not listed or described in your policy or in the optional coverage 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 optional coverage
- Upgrading of serviceable dentistry
- Services rendered prior to the optional coverage effective date, and services rendered on or after the optional coverage effective date that are directly related to services received before the optional coverage effective date

- Services rendered after the date of termination of the dental coverage
- Dental pit/fissure sealants on other than first and second permanent molars
- Diagnostic photographs
- Dietary instruction or other counseling
- Silicate restorations
- Sedative fillings
- Root canal therapy on other than permanent teeth
- Pulp capping (direct or indirect)
- 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
- 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
  - Surgical extraction of impacted teeth

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

Maternity Coverage Exclusions

Maternity coverage covers pregnancies that begin at least six months after the rider becomes effective even if you qualify for credit toward your base policy's 12 month pre-existing waiting period. Maternity and pregnancy-related benefits are only available to the female insured or the female covered spouse/domestic partner who is at least 18 years of age or an emancipated minor. It does not cover maternity services for dependent children or a male spouse. The six month time period may not apply to you if you meet certain eligibility requirements.

The maternity coverage helps pay for:

- Childbirth
- Prenatal and postnatal care
- Use of delivery room
- Hospital bed and board for mother
- Routine nursery care
- Routine newborn circumcision
- Cesarean section deliveries
- Diagnostic X-rays and lab charges

In addition, maternity coverage is not available for the following deductible options:

- Premier – $500 & $1,500 deductible options

Maternity coverage is not available on SmartSense, SmartSense with Enhanced Drug Benefit, CoreShare or Essential KeyCare.

Supplemental Accident Coverage Exclusions

The supplemental accident coverage covers ambulance services related to accidents. Exclusions listed in the policy apply to the Supplemental Accident rider.

For Essential KeyCare and KeyCare Preferred, this optional coverage does not cover any of the other capped benefits (benefits with yearly limits) listed in the Limitations section. The coverage also does not cover 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 optional coverage. Exclusions listed in the policy apply to the Supplemental Accident rider. For Premier, SmartSense, SmartSense with Enhanced Drug Benefit, CoreShare, KeyCare Flexible Choice and KeyCare HealthSmart with Enhanced Drug Benefit, in addition to the exclusions in the policy, the following exclusions apply to supplemental accident covered services. No payment will be made for prescription drugs, routine wellness care or the amount of a provider's charge which exceeds our allowable charge. This portion of the provider's charge will not be counted toward your out-of-pocket expense limit.

Preventive Care And Immunizations For Children Exclusions

Applies to Individual Essential KeyCare and KeyCare Flexible Choice only as this benefit is included under Premier, SmartSense, SmartSense with Enhanced Drug Benefit, CoreShare, KeyCare Preferred, Lumenos HSA, Lumenos HIA and KeyCare HealthSmart with Enhanced Drug Benefit. The preventive care and immunizations for children coverage provides routine preventive care and immunizations for covered children from birth through age 6. When a covered child turns 7, benefits under the preventive care and immunizations for children coverage ends.

Limitations

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

Benefits With Yearly Limits Under These Policies Are:	**Limit Per Benefit Calendar Year**
· Ground ambulance services (*No limit on Ambulance services for Lumenos HSA or HIA)	$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 and 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

For **Premier, SmartSense, and SmartSense with Enhanced Drug Benefit** $7,500*

For **CoreShare** $5,000*

· Dispensed at Pharmacy – Up to a 30 day supply per prescription

· Ordered through the WellPoint Next RX Pharmacy Service – Up to a 90 day supply per prescription

For **Lumenos HSA, Lumenos HIA, HealthSmart with Enhanced Drug Benefit, Flexible Choice, Essential KeyCare and KeyCare Preferred** $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 WellPoint Next RX Pharmacy Service – Up to a 90 day supply per prescription

* *Specialty drugs under Premier, SmartSense, SmartSense with Enhanced Drug Benefit, CoreShare, Flexible Choice, HealthSmart with Enhanced Drug Benefit, Lumenos HSA and Lumenos HIA – are not included in the annual maximum. In addition, specialty drugs can be purchased through Anthem's Specialty Pharmacy Network.*

Coinsurance Limitations

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

For **KeyCare Preferred and Essential KeyCare:**

· Coinsurance paid to a non-network 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 stays

· Coinsurance for dental services received from non-network providers. (Applies only to individual KeyCare Preferred)

For **Premier, SmartSense, SmartSense with Enhanced Drug Benefit and CoreShare:**

· Copayments

For **KeyCare Flexible Choice, KeyCare HealthSmart with Enhanced Drug Benefit, Premier, SmartSense, SmartSense with Enhanced Drug Benefit and CoreShare:**

· Coinsurance and copayments for prescription drugs and insulin

Dental Coverage Limitations

Diagnostic

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

Radiographic

· Set of bitewing X-rays (not in same year as full mouth series X-rays):
  - 1 each calendar year

· Full mouth series X-rays for covered persons age 5 and over:
  - 1 every 3 calendar years

· 9 or more bitewing or periapical X-rays taken at one time is considered a full mouth X-ray

· Up to 4 individual periapical films, but not in the same year as a complete mouth X-ray series, (does not apply when rendered in conjunction with emergency treatment.)

Preventive

· Dental cleaning, including periodontal cleanings:
  - 2 each calendar year

· Fluoride application for covered persons under age 16:
  - 2 each calendar year

· Space maintainers for covered persons under age 12:
  - 2 each per lifetime

· Sealants for each unrestored permanent first and second molar for covered persons under age 16:
  - 1 each per lifetime. There must be a lapse of at 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 is 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

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Adjunctive

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

Supplemental Accident Limitation

- With Premier, SmartSense, SmartSense with Enhanced Drug Benefit, CoreShare, Flexible Choice, and KeyCare HealthSmart with Enhanced Drug Benefit – Anthem pays 100% of the allowable charge, up to a total of $750 per person, per year. With Essential KeyCare and KeyCare Preferred, Anthem pays 100% of the allowable charge, up to $500 per accident.

Preventive Care And Immunizations For Children Coverage Limitation

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

This document provides a brief summary of provisions, exclusions and limitations. If there is any difference between this document and the Policy, the Policy will prevail. 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 forms 06714VAMEN, 06716VAMEN and 06718VAMEN, application forms MVAFR6672A - MVAFR6674A and optional rider forms AVA1563, AVA1393 and AVA1517.

Selecting health coverage is an important decision.

To assist you, we supply the following for the plans under consideration: Brochure, Benefit Guide, Coverage Details and Enrollment Application. If you did not receive one or more of these materials, please contact your Anthem Blue Cross and Blue Shield agent to request them.