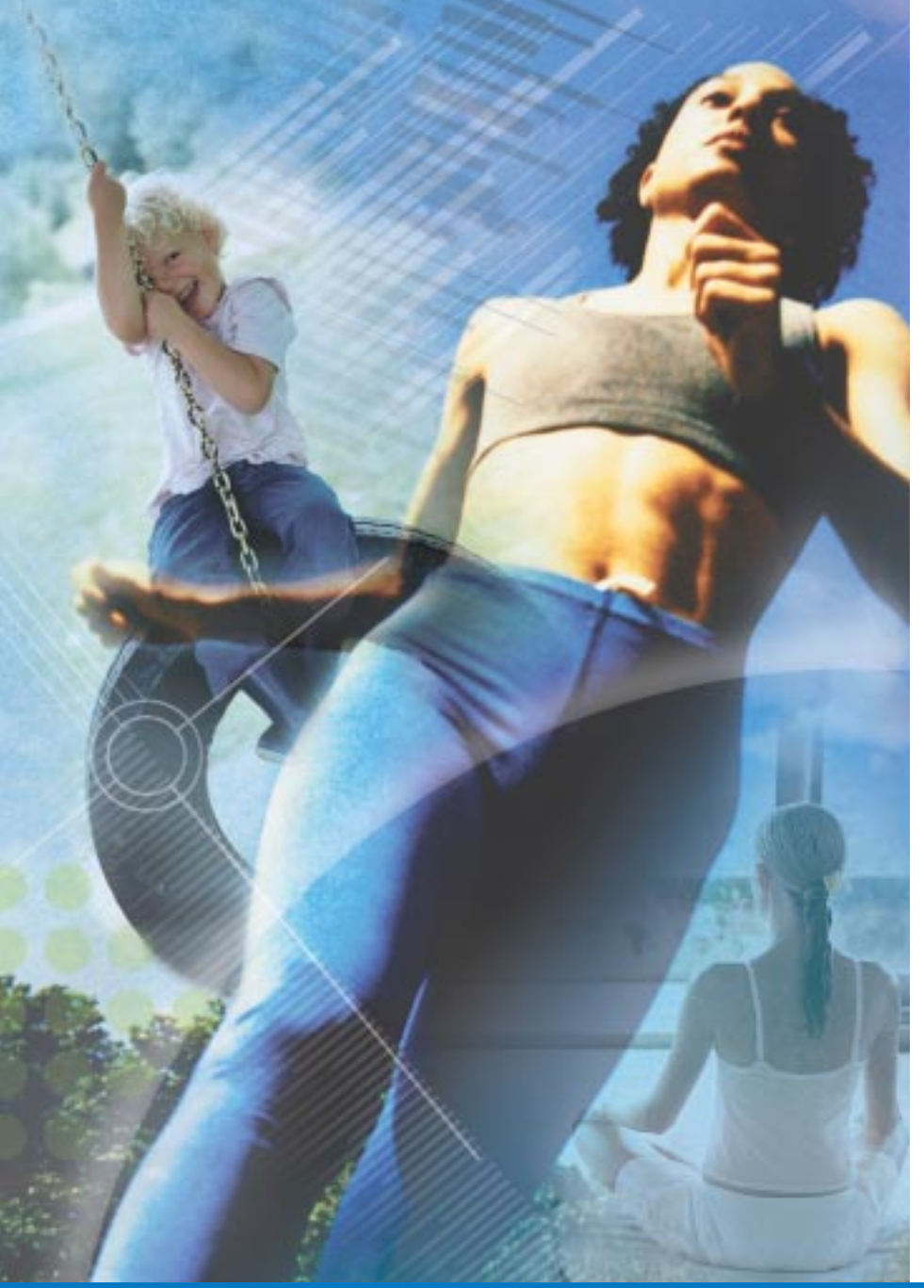


Anthem®

Health and Wellness Resources

Your Benefits and Discount Services

The Ins and Outs of Coverage

Anthem KeyCare

anthem.com

Anthem KeyCare members have the right to privacy and that right is respected by all Anthem Blue Cross and Blue Shield employees. We abide by the Commonwealth of Virginia Privacy Protection Act and have procedures in place to ensure your privacy. Any medical information we receive about Anthem KeyCare members, including medical records from health care professionals or hospitals, will be kept confidential and, except as permitted by law, will not be made available without the member's written permission. In a limited number of situations, Anthem Blue Cross and Blue Shield may need to release confidential information without written authorization (but within the law) in order to administer benefits – for example, conducting coordination of benefits between health care carriers. Anthem KeyCare members can review any personal information collected about them by Anthem Blue Cross and Blue Shield including medical records held by us by calling Member Services. Corrections to inaccurate information will be made at their request.

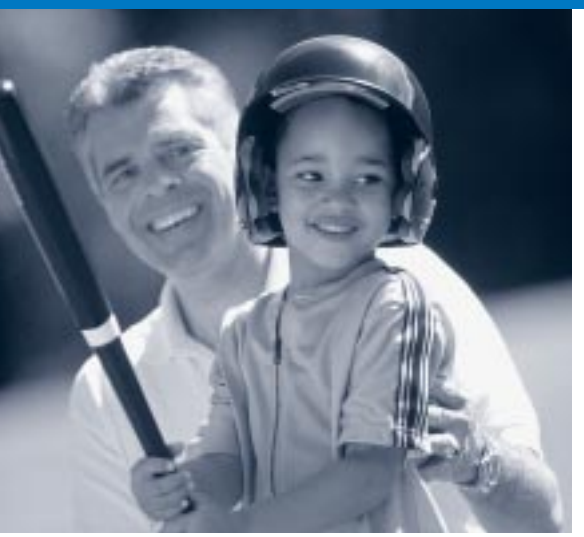
The confidentiality of Anthem KeyCare members' medical records is not just protected by law; Anthem Blue Cross and Blue Shield goes beyond the law's requirements to ensure privacy. All our employees are required to sign confidentiality statements keeping member records private, and by contract, members' employers are required to protect their records and are prohibited from misusing confidential information. Anthem Blue Cross and Blue Shield also contractually requires network health care professionals to keep member medical records confidential. Any medical information received on our members' behalf is kept secure and access to this information is limited to approved employees.

Anthem Blue Cross and Blue Shield operates Anthem KeyCare as a managed care health insurance plan ("called an MCHIP") subject to regulation in the Commonwealth of Virginia by both the State Corporation Commission Bureau of Insurance pursuant to Title 38.2 of the Virginia Code and the Virginia Department of Health pursuant to Title 32.1 of the Virginia Code.

How coverage is determined

Your Anthem KeyCare plan only covers medically necessary services. To be considered medically necessary, a service must be required to identify or treat an illness, injury, or pregnancy-related condition; be consistent with the symptoms or diagnosis and treatment of your condition; be in accordance with standards of generally accepted medical practice; and be the most suitable supply or level of service that can safely treat the condition and not be for the convenience of the patient, patient's family, or the provider. In addition, when a medically necessary service can be performed safely in a number of different settings, for example in a doctor's office, in a hospital outpatient department or as an inpatient, it will be covered when performed in the least costly of these settings. Knowing how your benefits apply to your treatment alternatives, you and your doctor can make an informed, final decision about your care that's the right decision for you.

Welcome to Anthem KeyCare



Do you have a plan for good health? With Anthem KeyCare, you do.

Your Anthem KeyCare plan gives you:

coverage for important health care services including:

- well and sick visits
- labs, x-rays and other types of tests
- emergency and urgent care
- annual routine eye exams
- maternity visits before and after having a baby
- care in a hospital

a team of doctors, nurses and other health care professionals who can:

- be there for you when you're sick
- help you make smart lifestyle choices to be in the best health you can
- take the time to listen to your concerns and answer your questions

access to discounts on:

- health and wellness products
- fitness clubs and health centers
- alternative medicine services
- vitamins and nutritional supplements
- eyewear and supplies
- laser vision correction surgery
- smoking cessation program

Anthem KeyCare

With Anthem KeyCare, you can choose a doctor across the street or across the country.

Anthem KeyCare members can choose to receive services from any doctor, hospital or other health care professional.

Those with an agreement to serve Anthem KeyCare members

Doctors, hospitals and other health care professionals with an agreement to serve members are also known as "network" professionals. When you become an Anthem KeyCare member, your identification card will carry the Cross and the Shield, two symbols that can expand your network of doctors, hospitals and other health care professionals to include all those affiliated with Blue Cross and Blue Shield PPO plans across the country and throughout the world! With participating professionals all across America* and nine out of ten* doctors in Virginia, there's a good chance the doctors you currently see are part of the network.

Using network doctors, hospitals and other health care professionals has its advantages. These network professionals have agreed to accept set fees as payment for their services. Plus, they will file claim forms and handle any authorizations for you.

Those without an agreement to serve Anthem KeyCare members

You can use doctors, hospitals and other health care professionals that don't have agreements to serve Anthem KeyCare members. These professionals are often called "out-of-network." There are doctors, hospitals and other health care professionals that do not have agreements to serve members in Anthem KeyCare plans but do have agreements with us or other Blue Cross and Blue Shield plans to serve members in our other health plans. While these professionals are still considered "out-of-network" for Anthem KeyCare members, they will accept set fees as payment for their services.

Professionals that do not have any agreements with us or other Blue Cross and Blue Shield plans can charge whatever they want for their services. Typically, when you receive covered services from these out-of-network doctors, hospitals and other health care professionals, we will pay a set percentage of the amount we pay doctors, hospitals and other health care professionals that have an agreement with us for the same service. You will pay the rest. If what these out-of-network professionals charge is more than what we pay, they can bill you for the difference between the two amounts. Payments to out-of-network professionals will never be more than what we would have paid to a participating provider.

** Blue Cross and Blue Shield Association, April 2003*

Health and Wellness Resources

Services that require advance reviews

Network doctors, hospitals and other health care professionals will work with us to make sure certain procedures and services are reviewed to see if they can be covered under your Anthem KeyCare plan. This "prior authorization" is done for stays in a hospital or a skilled nursing facility and is recommended for all outpatient mental health and substance abuse care as well.

If you're not using a network professional, you need to work with us to complete your hospital admission review before your inpatient stay. If you are admitted to the hospital directly from the emergency room, you (or someone on your behalf) need to contact us within 48 hours of your admission. You should also call us to get prior authorization for outpatient mental health and substance abuse services you want to receive from a doctor, hospital or other health care professional that doesn't participate with Anthem Blue Cross and Blue Shield.

Health care coverage when you need it — at home or on the road

When you are an Anthem KeyCare member, your identification card carries the Cross and the Shield — two symbols that can help make seeking services under your health plan easy, no matter where you are. There are affiliated Blue Cross and Blue Shield plans across the United States as well as in countries across the world that combine to participate in the "BlueCard® PPO" program. Almost all Anthem KeyCare members can use this international network of doctors, hospitals and other health care professionals. That means there's a good chance a network doctor, hospital or other health care professional is near you… wherever you may be. The BlueCard® PPO program is not available to Point of Service members.

Anthem KeyCare

The Anthem KeyCare Point of Service (POS) Plan

With your Anthem KeyCare POS plan, you will choose one network doctor who will provide or coordinate most of your health care — a primary care physician. You and all your covered family members can choose your own primary care physicians from family practitioners, general practitioners and internists. Pediatricians can serve as primary care physicians for children. Lists of these doctors are available at www.anthem.com and by calling Member Services.

Your primary care physician will refer you to network specialists and will work with us to obtain prior authorization for services when necessary. You can coordinate certain specialist visits on your own — without your primary care physician — for: an annual routine eye exam; routine outpatient non-surgical ob/gyn or nurse-midwife care; mammograms; emergency care; outpatient radiation therapy; chemotherapy; dialysis treatments; infusion therapy; outpatient diagnostic services; outpatient oral surgery services or covered services in conjunction with a dental accident; and outpatient mental health and substance abuse services. When you receive covered services as described above, you are receiving "in-plan" services. Typically you will pay less when receiving in-plan services.

You also have the option of not using a primary care physician to coordinate or provide your care. You can also use doctors, hospitals and other health care professionals not in the network. When you do this, the covered services you receive are called out-of-plan. Typically you will pay more when you receive out-of-plan services.

Anthem KeyCare Deductible Plans

If your plan includes a deductible requirement, covered services that are received during the last three months of the calendar year that are applied to your deductible may also be applied to the deductible required for the following year.

Emergency care

An *emergency* is the sudden onset of a medical condition with such severe symptoms that a person with an average knowledge of health and medicine (also called a "prudent lay person") would seek medical care immediately because there may be:

- serious risk to mental or physical health
- danger or significant impairment of body functions
- significant harm to organs in the body (heart, brain, kidneys, liver, lungs, etc.)
- danger to the health of the baby in a pregnant woman

If you ever need emergency medical care as described above, go immediately to the nearest medical facility. Emergency care is covered no matter where the services are received. You (or someone on your behalf) should call us within 48 hours after receiving emergency care services.

When you're admitted to the hospital or skilled nursing facility

Isn't it good to know that while you're an inpatient in the hospital or skilled nursing facility, you have an entire team working on your behalf? Made up of your doctor, the nurses and discharge planners at the hospital or skilled nursing facility and the Anthem KeyCare doctors and nurses on our staff, the Helping You Home® team is working to help make sure you get the right care in the right place at the right time.

Before you go to the hospital or skilled nursing facility…

Your team is involved in your care from the start and are the ones who discuss the need for you to be admitted to a hospital or skilled nursing facility (called "prior authorization"). With advances in technology, many medical procedures that once could only be done in a hospital can be done safely in a doctor's office or as day surgery in an outpatient setting.

While you're there…

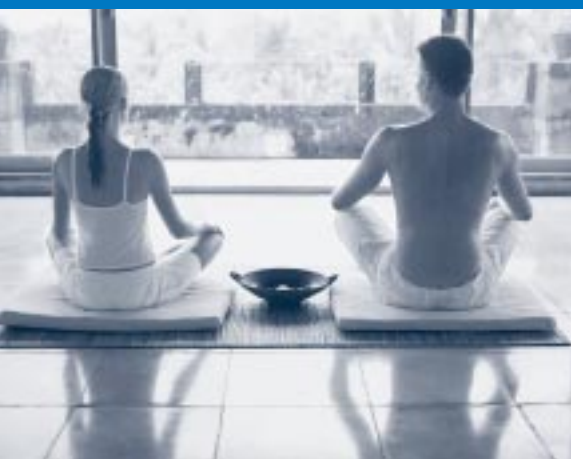
Once you're admitted to a hospital or skilled nursing facility, the Helping You Home team focuses on the care you're receiving while you're an inpatient. The nurses and doctors make sure you're getting the right services for your condition, and just as important, make sure you're not going through unnecessary procedures. This phase is called "concurrent review" and tracks the progress you're making while you're still in the hospital or skilled nursing facility.

When you leave…

When it's time for you to leave the hospital or skilled nursing facility, the Helping You Home team has finalized the plan that can help you make a smooth transition back home. They can even help coordinate the services you'll need once you're ready to leave, whether or not they are covered under your Anthem KeyCare plan. Some of the factors considered by your team include:

- Do you need a specialized van to take you home or can a family member drive you?
- Do you need a hospital bed at home?
- Will you need home visits by a nurse?
- Do you need crutches, a walker or any other type of durable medical equipment?
- Will bandages need to be changed? Will you need a medical professional to do it or can you change them yourself?

Anthem KeyCare



Expecting a baby?

Going to the doctor as soon as you suspect you're pregnant and continuing to get checkups and wellness visits throughout your pregnancy is the best way to start off your baby's life. Having good, reliable information about what to expect during the pregnancy and after the baby is born is important as well.

Baby Benefits, a prenatal program that accompanies your Anthem KeyCare plan and is administered by our affiliated company, Health Management Corporation, involves your entire family with the pregnancy by providing information for the expectant mother, father and the rest of the family members. Your family will also be able to use the services of a specialized team of obstetric nurses, on-call for you 24 hours a day. These specially-trained nurses will work with you and your doctors to help prevent premature births and make sure the pregnancy is the healthiest possible. You'll also receive a congratulatory baby gift once your baby's born.

Visit us online

Anthem.com is your resource for the health care answers you need.

Member self-service

- Update your personal information.
- Determine the status of your claims or download them for your records.
- Use our secure message center to submit any questions you have about your coverage.
- Lost your ID card? Order a new one here.

Hospital quality comparison tool

- Discover how your hospital compares for procedures performed, complication rates and critical resources, such as intensive care units and the latest technology.

Treatment decision support tool

- Explore what you need to know to make the most informed decisions about your health — including the questions to ask your doctor, treatment options, community resources and issues to consider.

Answers@Anthem

- Search the provider directory for doctors, and even get driving directions to their office.
- Get up to speed on the medicines you take, their typical cost, alternative medications that may work just as well for less money out of your pocket, and information about interactions with other medicine you may be taking.

Plus…

- Use ***Cool Tools*** for interactive learning on everything from your child's adult height predictor to how much your smoking habit really costs you.
- Find help for that nagging backache through the ***Medical Library*** that covers over 2,500 topics.
- Feel like your treadmill's getting you nowhere? Check out the ***Fitness & Nutrition*** section to find an exercise plan that will help you meet your goals.
- Take advantage of member discounts on fitness clubs, weight loss programs, smoking cessation tools and phone support services, laser correction surgery and more through ***SpecialOffers@Anthem***.

www.anthem.com

Health and Wellness Resources

Keep up with the latest health news

You'll be right on top of the latest health and wellness news with the *Anthem Healthy Solutions* newsletter. Mailed to your home four times a year and available online at www.anthem.com, the articles and information can help you make smart decisions about your health care.

Living with asthma, diabetes, congestive heart failure or coronary artery disease?

Through Better Prepared℠ you can partner with specialized registered nurses who will answer any questions you have, give you information on the latest treatments available and work with your doctor to coordinate your health care services and resources. Better Prepared is administered through our affiliated company, Health Management Corporation.

Access to wellness programs and discount services

Your Anthem KeyCare plan covers a wide range of benefits to help you be as healthy as possible. Living a healthy lifestyle and knowing how to make smart lifestyle choices can often improve health and are two of the reasons why your Anthem KeyCare plan gives you access to discount services in addition to health and wellness programs. The discount services listed within this brochure and the *Anthem Healthy Solutions* are not covered as benefits or guaranteed under your Anthem KeyCare plan and can be discontinued at any time.

Health and wellness resources

- access to doctors, hospitals and other health care professionals from coast to coast
- a team of doctors, nurses and other health care professionals working on your behalf
- access to discounts on alternative medicine services, health clubs, fitness centers
- access to prenatal programs
- a quarterly newsletter

Your Anthem KeyCare plan provides access to programs and discount services to expand your wellness resources.

Anthem KeyCare

Your Anthem KeyCare plan has a focus on health and wellness.

The amount you pay for covered services can vary depending on the type of doctor you see. You pay less when you see a doctor that is a family practitioner, general practitioner, internist or pediatrician. You pay more when you see a doctor that has a different specialty.

Your costs for covered screenings depends on the type of test and where it is performed. Using the colorectal cancer screening as an example, a sigmoidoscopy performed in an internist's office typically will cost less than one performed in a specialist's office or an outpatient hospital setting.

Coverage when you're feeling good...

You don't have to wait to be sick or injured before using your Anthem KeyCare plan. In fact, you have coverage for services that you can use when you're feeling fine. Your Anthem KeyCare coverage includes a wide range of wellness services in addition to preventive care and screenings:

- well baby visits, including recommended immunizations and tests
- an annual checkup
- an annual mammogram for members age 35 and older
- an annual gynecological exam for women (including a breast exam, pelvic exam and Pap test performed by any FDA-approved gynecological cytology screening technologies)
- prostate exams and an annual Prostate Specific Antigen (PSA) test for men age 40 and older
- colorectal cancer screenings (an annual fecal occult blood test, a barium enema, a flexible sigmoidoscopy or a colonoscopy in accordance with age, family history and frequency recommendations of the American College of Gastroenterology in consultation with the American Cancer Society)
- additional dollars for immunizations and other labs and x-rays done in connection with an annual checkup
- an annual routine eye exam
- outpatient maternity care throughout pregnancy (one payment covers all prenatal and postnatal office visits)

...and when you are not

When you aren't feeling good or are injured — even if you think it's minor — you can count on your Anthem KeyCare coverage. Some of the services covered by your plan include:

- office visits
- diagnostic tests, labs and x-rays
- shots and injections
- physical, speech and occupational therapy
- surgery
- stays in a hospital or skilled nursing facility
- home health care services
- ambulance services
- medical equipment, supplies and appliances
- emergency care

Your Benefits and Discount Services

Healthy starts

Your Anthem KeyCare plan can help the youngest members of your family get off to the healthiest start possible. Coverage for well visits, immunizations and screenings is based on the recommendations of the American Academy of Pediatrics as well as those prescribed by Virginia's Commissioner of Health for children through age 6 including:

Childhood Immunizations

DTP (Diphtheria, Tetanus, Pertussis)
Polio
HIB (Hemophilus Influenza B)
Hepatitis B
MMR (Measles, Mumps, Rubella)
Pneumococcal Conjugate
Varicella (Chicken Pox)

Childhood Screening Tests

Blood tests (HGB/HCT/FEP)
Urine tests
Tuberculin tests
Pure tone audiogram tests
Machine vision tests
Testing for congenital adrenal hyperplasia
Infant hearing screenings and other audiological exams

While these immunizations can provide a good foundation for health, some children will need special services during the first years of their lives. Children up to age 3 who are certified by the Department of Mental Health, Mental Retardation, and Substance Abuse Services (referred to as "DMH") as eligible under Part H of the Individuals with Disabilities Education Act are covered for early intervention services. These services are designed to help children reach or retain function so they are on a similar level with other children their age and include speech and language therapy, occupational therapy, physical therapy as well as assistive technology services and devices. These early intervention services are limited to a combined maximum of $5,000 per calendar year and the amount you pay is determined by the service received.

Tailor your wellness package

Members age 7 and older can work with their doctors to develop a preventive care and wellness plan personalized for their needs. Coverage includes:

- an annual checkup
- an allowance for immunizations, labs and x-rays done in connection with the annual checkup
- an annual gynecological exam
- an annual mammogram for members 35 and older
- an annual PSA test and prostate exams for men 40 and older
- colorectal cancer screenings

Your benefits and discount services

- preventive care and wellness benefits
- an annual routine eye exam
- office visits
- diagnostic services
- inpatient care
- emergency care
- discounts on eyewear and laser vision correction surgery

Routine eye exam

To receive your annual routine eye exam for $15, you need to use an eye care professional in the Davis Vision network. You can use eye care professionals outside of the Davis Vision network for the annual routine eye exam, but you will pay more.

An eye on savings

Visit Davis Vision network providers for discounts of up to 25% on laser vision correction surgery as well as discounts on eyewear.

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Anthem KeyCare 15 Plan

In-network services	*You pay*
Checkups and sick visits • office visits • urgent care visits • home visits • pre- and postnatal office visits (you will pay one payment per pregnancy) • mental health and substance abuse visits • in-office surgery • well baby visits • an annual checkup visit • an annual gynecological exam • prostate exams • immunizations (no charge when given to children under age 7) • physical and occupational therapy visits in an office setting (combined $2,000 maximum) • speech therapy visits in an office setting ($500 maximum) • spinal manipulations and other manual medical intervention visits ($500 maximum)	**$15** for each visit to a family or general practitioner, internist or pediatrician **$30** for each visit to a specialist
Labs, x-rays and other outpatient services • lab services • x-rays • an annual mammogram for members age 35 and older • Pap tests • an annual Prostate Specific Antigen (PSA) test for men age 40 and older • shots and therapeutic injections • medical appliances, supplies and medications • durable medical equipment ($5,000 maximum) • dialysis • chemotherapy, IV, radiation and respiratory therapy • professional ground ambulance services ($3,000 maximum)	**20%** of the amount the health care professionals in our network have agreed to accept for their services
Plus Up to $150 per calendar year for family members age 7 and older for additional routine immunizations, and all other routine labs and x-rays done in connection with annual checkups. For labs and x-rays, you will pay 20% of the fee our network health care professionals have agreed to accept for these services. We will pay the remaining 80% for these services as well as 100% of the cost of the immunizations until the amount paid by us reaches $150. Then you will pay 100% of the cost of the additional immunizations, labs and x-rays done as part of an annual checkup. The costs of the annual mammogram, Pap, PSA and colorectal cancer screening tests will not count toward this $150 of additional coverage.	
Routine vision • an annual routine eye examination	**$15** for each visit
Plus valuable discounts on: eyewear and laser vision correction surgery	
Other outpatient visits in a hospital or facility • physical therapy and occupational therapy (combined $2,000 maximum) • speech therapy ($500 maximum)	**$30 plus 20%** of the amount the health care professionals in our network have agreed to accept for their services
• emergency room • surgery * *For the services billed by the doctor, you will pay an additional **$15** or **$30** depending on the type of doctor that treats you.*	**$100 plus 20%** of the amount the health care professionals in our network have agreed to accept for their services *

For the benefits listed with specific limits, all services received during the calendar year from January 1 to December 31 for that benefit (whether received in-network or out-of-network) are applied to that limit.

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In-network services	*You pay*
Care at home • home health care visits by a nurse or aide (90 visits) • hospice care	**No charge**
• private duty nursing ($500 maximum)* * *Since there is no network for this service, you may be billed for the difference between what we pay for this service and the amount the private duty nursing service charged.*	**20%** of the amount we have agreed to pay for their services
Inpatient stays in a network hospital or facility • semi-private room, intensive care or similar unit * *You do not have to pay another **$300** if you are readmitted within 90 days of the day you went home.*	**$300 plus 20%** of the amount the health care professionals in our network have agreed to accept for their services *
• physician, nursing and other medically necessary professional services in the hospital including anesthesia, surgical and maternity delivery services • skilled nursing facility care (100 days for each admission) • mental health and substance abuse partial day treatment programs	**20%** of the amount the health care professionals in our network have agreed to accept for their services

Out-of-network services

Using doctors, hospitals and other health care professionals not contracted to provide benefits

It's important to remember that health care professionals not in our network can charge whatever they want for their services. If what they charge is more than the fee our network health care professionals have agreed to accept for the same service, they may bill you for the difference between the two amounts. You will pay all the costs associated with the covered services outlined in this insert until you have paid $400 in one calendar year.

- If two people are covered under your plan, each of you will pay the first $400 of the cost of your care ($800 total).
- If three or more people are covered under your plan, together you will pay the first $800 of the cost of your care. However, the most one family member will pay is $400.

Once you have reached this amount, when you receive covered services we will pay 70% of the fee our network health care professionals have agreed to accept for the same service. You will pay the rest, including any difference between the fee our network health care professionals have agreed to accept for the same service and the amount the health care professional not in our network charges. If you go to a Virginia hospital or a Virginia mental health, drug and alcohol program specializing in partial day treatment not in the network, our payment will decrease to 50%. You will pay the rest, including any difference between the fee our network health care professionals have agreed to accept for the same service and the amount the health care professional not in our network charges. If you go to an eye care professional not in our network for your routine eye examination, we will pay $30 (whether or not you have reached the $400 calendar year amount) and you will pay the rest of what the professional charges.

Out-of-pocket maximums

What you will pay for covered services in one calendar year (January 1 — December 31)

When using network professionals:

If you are the only one covered by your plan, you will pay $2,000 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is $0, except for services listed below.

- If two people are covered under your plan, each of you will pay $2,000 ($4,000 total).
- If three or more people are covered under your plan, together you will pay $4,000. However, no family member will pay more than $2,000 toward the limit.

When not using network professionals:

If you are the only one covered by your plan, you will pay $4,000 for covered services outlined in this insert. Once you have reached this amount, your payment for covered services is $0, except for services listed below.

- If two people are covered under your plan, each of you will pay $4,000 ($8,000 total).
- If three or more people are covered under your plan, together you will pay $8,000. However, no family member will pay more than $4,000 toward the limit.

The following do not count toward the calendar year payment limit. You will still need to pay:

- your share of the cost of care received in hospitals and other facilities that do not have an agreement with us or another Blue Cross and Blue Shield plan
- your share of the cost of prescription drugs and routine vision care
- the cost of care received when the benefit limits have been reached
- the cost of services and supplies not covered under your Anthem KeyCare 15 plan
- the additional amount health care professionals not in our network may bill you when their charge is more than what we pay

This benefits overview insert is only one piece of your entire enrollment package.
Exclusions and limitations are in the enrollment brochure.

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Anthem KeyCare

Now that you've read about the coverage an Anthem KeyCare plan offers — the benefits, special programs and discount services — it's also important that you take the time to read this section. It outlines who can enroll in your Anthem KeyCare plan, when and how your coverage can change, what's not covered by your plan and how your plan works with any other health care coverage you have.

Children are covered until December 31st of the year they turn 23

Who you can cover

You can choose coverage for you alone or family coverage that includes you and any of the following family members:

- your husband or wife
- your unmarried natural children including children you have adopted or are in the process of adopting
- your unmarried stepchildren or children for whom you are the legal guardian if you provide more than one half of their support

Some children have mental or physical challenges that prevent them from living independently. The dependent age limit does not apply to these enrolled children as long as these challenges were present before they reached age 23.

How and when your coverage can be changed

Your Anthem KeyCare coverage can be renewed, cancelled or changed on two different levels. The first is on the employer level, which would impact you and everyone else covered under your employer's plan. The second level impacts your coverage only — including your covered family members — and does not apply to any others covered under your employer's plan.

Ins and Outs of Coverage

1. On the employer level — which impacts you as well as all employees under your employer's plan — your Anthem KeyCare plan can be…

renewed	cancelled	changed	when…
✓			your employer maintains its status as an employer, remains located in our service area, meets our guidelines for employee participation and premium contribution, pays the required health care premiums and does not commit fraud or misrepresent itself.
	✓		after a 31-day grace period, your employer still does not pay the required health care premium (at least a 15-day notice will be given to your employer) or makes a bad payment or your employer can voluntarily cancel coverage by giving us a 30-day advance written notice.
	✓		we decide to no longer offer the specific plan chosen by your employer (you'll get a 90-day advance notice) or if we decide to no longer offer any coverage in Virginia (you'll get a 180-day advance notice).
		✓	your employer and you received a 30-day advance written notice that the coverage was being changed (services added to your plan or the copayment amounts decreased). Copayments can be increased or services can be decreased only when it is time for your group to renew its Anthem KeyCare coverage.

2. On an individual level — factors that apply to you and covered family members — your Anthem KeyCare plan can be...

renewed	cancelled	when…
✓		you maintain your eligibility for coverage with your employer, pay your required portion of the health care premium and do not commit fraud or misrepresent yourself.
	✓	you purposely give wrong information about yourself or your dependents when you enroll. Cancellation is effective immediately.
	✓	you lose your eligibility for coverage, don't make required payments or make bad payments, commit fraud, are guilty of gross misbehavior, don't cooperate with coordination of benefits recoveries, let others use your ID card, use another member's ID card or file false claims with us. Your coverage will be cancelled after you receive a written notice from us.

Have you had health care coverage before? Are you covered by a health care plan now?

When you first enroll in Anthem KeyCare

Have you been treated for or diagnosed as having a specific condition other than pregnancy? If you have been, did the diagnosis or treatment occur less than 6 months before the date you will begin coverage under your employer's Anthem KeyCare plan or by the start of the waiting period required by your employer, whichever is earlier? If so, there is a 12-month period when services will not be covered for those specific conditions — often called "pre-existing conditions." All other covered services not related to the pre-existing conditions will be available beginning on your first day as a Anthem KeyCare member. If you or a covered family member have had breast cancer and have been disease free for five years, it is not considered a pre-existing condition, even if you have had routine follow-up visits to monitor for reoccurrence within the past 6 months or during your employer's required waiting period.

Your 12-month waiting period can be reduced by the number of months of "creditable coverage" you have before your Anthem KeyCare coverage starts. Creditable coverage is earned by having coverage under most types of group or individual:

- health insurance programs
- HMO plans
- health service plans
- fraternal society plans, or
- publicly-sponsored plans like Medicare, Medicaid or TRICARE.

You should receive verification of this coverage (called a "certificate of creditable coverage") from either the employer with whom you had the coverage or the health care company that provided it. Call Member Services if you'd like our help in obtaining your certificate of coverage. If you go more than 63 days without health care coverage, your past health care coverage is not considered creditable coverage.

Ins and Outs of Coverage

The chart below shows the effect creditable coverage can have on the 12-month waiting period.

No waiting period	Reduction in the 12-month waiting period	when…
✓		your employer has at least 10 employees and is switching your coverage to Anthem KeyCare and you have been enrolled under your employer's previous health care plan.
✓		an infant, within 31 days of birth, has been covered under a group or individual insurance or HMO plan, service plan, fraternal plan, or a publicly-sponsored plan like Medicare, Medicaid or TRICARE or other plan as described in the member booklet.
✓		children you have adopted or are going to adopt are under the age of 18 and • have been covered under a group insurance or HMO plan, a government plan (Medicare, Medicaid, TRICARE or other similar publicly-sponsored program) or other plan as described in the member booklet within 31 days of the adoption or placement and did not go more than 63 days without coverage, and • will be enrolled in your Anthem KeyCare coverage within 31 days of their initial eligibility. Otherwise, they may not be eligible to enroll in your plan for up to one year.
	✓	you have just joined an employer who has been offering Anthem KeyCare coverage and you were covered by another health plan before enrolling in your new employer's Anthem KeyCare plan. Often the waiting period will be reduced by the number of months you were covered under your former employer's plan.

Factors used to set the price of health care coverage for employers with 2 to 99 employees

- the Anthem KeyCare plan selected by your employer
- your employer's location
- the age of each employee
- the number of enrolled employees
- the number of dependents enrolled by each employee
- the health status of the enrolled employees and their dependents

Additional factors for employers with 15-99 employees

- the gender of enrolled employees
- your employer's industry

An additional factor for employers with 51-99 employees

- any applicable commission paid to sales representatives and brokers

Anthem KeyCare

When you'll be covered by Anthem KeyCare and another health care plan

Coordination of Benefits (COB) helps our members who are covered by more than one group health plan ensure they receive the benefits to which they are entitled while avoiding overpayment by either carrier. Because current and accurate information is the key to our Coordination of Benefits program, Anthem KeyCare members can expect to receive a COB questionnaire on an annual basis. Timely response to these questionnaires will help avoid delays in claims payment.

When a member is covered by two different group health plans, one is considered primary and the other is considered secondary. The primary carrier is the first to pay the claim and provides reimbursement according to plan allowances; the secondary carrier then provides reimbursement, typically covering the remaining allowable expenses.

Determining the primary versus secondary carrier

The following rules apply when determining which health plan is the primary carrier. The term "participant" is used and means the person who is signing up for coverage:

When a person is covered by 2 group plans, and	Then	Primary	Secondary
One plan does not have a COB provision	The plan without COB is	✓	
	The plan with COB is		✓
The person is the participant under one plan and a dependent under the other	The plan covering the person as the participant is	✓	
	The plan covering the person as a dependent is		✓
The person is the participant in two active group plans	The plan that has been in effect longer is	✓	
	The plan that has been in effect the shorter amount of time is		✓
The person is an active employee on one plan and enrolled as a COBRA participant	The plan in which the participant is an active employee is	✓	
	The COBRA plan is		✓
The person is covered as a dependent child under both plans	The plan of the parent whose birthday occurs earlier in calendar year (known as the birthday rule) is	✓	
	The plan of the parent whose birthday is later in the the calendar year is		✓
	Note: When the parents have the same birthday, the plan that has been in effect longer is	✓	
The person is covered as a dependent child and coverage is stipulated in a court decree	The plan of the parent primarily responsible for health coverage under the court decree is	✓	
	The plan of the other parent is		✓

When a person is covered by 2 group plans, and	Then	Primary	Secondary
The person is covered as a dependent child and coverage is not stipulated in a court decree	The custodial parent's plan is	✓	
	The non-custodial parent's plan is		✓
The person is covered as a dependent child and the parents share joint custody	The plan of the parent whose birthday occurs earlier in the calendar year is	✓	
	The plan of the parent whose birthday is later in the calendar year is		✓
	Note: When the parents have the same birthday, the plan that has been in effect longer is	✓	

Medicare coverage is available to certain individuals who are under age 65. Payment coordination with Medicare is shown below:

When a person is covered by Medicare and a group plan, and	Then	Anthem KeyCare is Primary	Medicare is Primary
Is a person who is qualified for Medicare coverage due solely to End Stage Renal Disease (ESRD-kidney failure)	During the 30-month Medicare entitlement period	✓	
	Upon completion of the 30-month Medicare entitlement period		✓
Is a disabled member who is allowed to maintain group enrollment as an active employee	If the group plan has more than 100 participants	✓	
	If the group plan has fewer than 100 participants		✓
Is the disabled spouse or dependent child of an active full-time employee	If the group plan has more than 100 participants	✓	
	If the group plan has fewer than 100 participants		✓
Is a person who becomes qualified for Medicare coverage due to ESRD after already being enrolled in Medicare due to disability	If Medicare had been secondary to the group plan before ESRD entitlement	✓	
	If Medicare had been primary to the group plan before ESRD entitlement		✓

Right of recovery

If health care benefits are inadvertently overpaid, reimbursement for the overpayment will be requested. Your help in the recovery process would be appreciated. We reserve the right to recover any overpayment from:

- any person to or for whom the overpayments were made;
- any health care company; and
- any other organization.

Anthem KeyCare

This list of services and supplies that are excluded from coverage by your health plan will not be covered in any case.

A

- **acupuncture**.

B

- **biofeedback therapy**.

C

- over the counter **convenience** and hygienic items. These include, but are not limited to, adhesive removers, cleansers, underpads, and ice bags.

- **cosmetic surgery** or **procedures**, including complications that result from such surgeries and/or procedures. Cosmetic surgeries and procedures are performed mainly to improve or alter a person's appearance including body piercing and tattooing. However, a cosmetic surgery or procedure does not include a surgery or procedure to correct deformity caused by disease, trauma, or a previous therapeutic process. Cosmetic surgeries and/or procedures also do not include surgeries or procedures to correct congenital abnormalities that cause functional impairment. We will not consider the patient's mental state in deciding if the surgery is cosmetic.

D

- the following **dental** services:

— treatment of natural teeth due to diseases or treatment of natural teeth due to accidental injury for which a treatment plan was not submitted to Anthem within 60 days of your date of injury.

— dental care, treatment, supplies, or dental x-rays;

— damage to your teeth due to chewing or biting is not deemed an accidental injury and is not covered;

— oral surgeries or periodontal work on the hard and/or soft tissue that supports the teeth meant to help the teeth or their supporting structures;

— appliances for temporomandibular joint pain dysfunction; or

— periodontal care, prosthodontal care or orthodontic care.
This exclusion will not apply if your group's coverage includes a dental rider.

- **donor** searches for organ and tissue transplants, including compatibility testing of potential donors who are not immediate, blood related family members (parent, child, sibling).

E

- **educational** or teacher services except in limited circumstances.

- **experimental/investigative** procedures, as well as services related to or complications from such procedures except for clinical trial costs for cancer as described by the National Cancer Institute. Nothing in this

exclusion will prevent a member from appealing our decision that a service is experimental/investigative.

F

- the following **family planning** services. These include:

— birth control medicine and devices unless prescribed for reasons other than birth control;

— services for artificial insemination or in vitro fertilization or any other types of artificial or surgical means of conception including any drugs administered in connection with these procedures;

— drugs used to treat infertility; or

— reversals of sterilization.

- services for palliative or cosmetic **foot** care including:

— flat foot conditions;

— support devices, arch supports, foot inserts, orthopedic and corrective shoes that are not part of a leg brace and fittings, castings and other services related to devices of the feet;

— foot orthotics;

— subluxations of the foot;

— corns;

— bunions (except capsular or bone surgery);

— calluses;

— care of toenails;

— fallen arches;

— weak feet;

— chronic foot strain; or

— symptomatic complaints of the feet.

H

- routine **hearing care** or hearing aids or exams for these devices except as described in this booklet.

- the following **home care** services:

— homemaker services;

— maintenance therapy;

— food and home delivered meals; or

— custodial care and services.

- the following **hospital** services:

— guest meals, telephones, televisions, and any other convenience items received as part of your inpatient stay;

— care by interns, residents, house physicians, or other facility employees that are billed separately from the facility; or

— a private room unless it is medically necessary.

M

- **maternity** benefits for your unmarried children.

- **medical equipment, appliances and devices, and medical supplies** that have both a non-therapeutic and therapeutic use. These include:

— exercise equipment;

— air conditioners, dehumidifiers, humidifiers, and purifiers;

— hypoallergenic bed linens;

— whirlpool baths;

— handrails, ramps, elevators, and stair glides;

— telephones;

— adjustments made to a vehicle;

— foot orthotics;

— changes made to a home or place of business; or

— repair or replacement of equipment you lose or damage through neglect.

Coverage does not include benefits for medical equipment (durable) that is not appropriate for use in the home.

- services or supplies if they are deemed not **medically necessary** as determined by Anthem at its sole discretion. Nothing in this exclusion shall prevent a member from appealing our decision that a service is not medically necessary.

However, if you receive inpatient or outpatient services that are denied as not medically necessary, or are denied for failure to obtain the required pre-authorization ** [or primary care physician referral] **, the following professional provider services that you receive during your inpatient stay or as part of your outpatient services will not be denied under this exclusion in spite of the medical necessity denial of the overall services:

For inpatients

1. services that are rendered by professional providers who do not control whether you are treated on an inpatient basis, such as pathologists, radiologists, anesthesiologists, and consulting physicians.

How new medical technologies are evaluated

Many of the Anthem KeyCare medical directors and staff actively participate in a number of national health care committees that review and recommend new treatments for coverage. To be approved for coverage, the service or product must have:

- regulatory approval from the Food and Drug Administration;
- been put through extensive research study to find all the benefits and possible harms of the technology;
- benefits that are far better than any potential risks;
- at least the same or better effectiveness as any similar service or procedure already available; and
- been tested enough so that we can be certain it will result in positive results when used in real cases.

2. services rendered by your attending provider other than inpatient evaluation and management services provided to you. Inpatient evaluation and management services include routine visits by your attending provider for purposes such as reviewing patient status, test results, and patient medical records. Inpatient evaluation and management visits do not include surgical, diagnostic, or therapeutic services performed by your attending provider.

For outpatients – services of pathologists, radiologists and anesthesiologists rendering services in an (i) outpatient hospital setting, (ii) emergency room, or (iii) ambulatory surgery setting. However, this exception does not apply if and when any such pathologist, radiologist or anesthesiologist assumes the role of attending physician.

• the following **mental health services and substance abuse services**:

— inpatient stays for environmental changes;

— cognitive rehabilitation therapy;

— educational therapy;

— vocational and recreational activities;

— coma stimulation therapy;

— services for sexual deviation and dysfunction;

— treatment of social maladjustment without signs of a psychiatric disorder;

— remedial or special education services; or

— inpatient mental health treatments that meet the following criteria:

- more than 2 hours of psychotherapy during a 24-hour period in addition to the psychotherapy being provided pursuant to the inpatient treatment program of the hospital;
- group psychotherapy when there are more than 8 patients with a single therapist;
- group psychotherapy when there are more than 12 patients with two therapists;
- more than 12 convulsive therapy treatments during a single admission; or
- psychotherapy provided on the same day of convulsive therapy.

N

• **nutrition** counseling and related services, except when provided as part of diabetes education.

O

- care of **obesity** or *services* related to weight loss or dietary control, including complications that directly result from such surgeries and/or procedures. This includes weight reduction therapies/activities, even if there is a related medical problem. Notwithstanding provisions of other exclusions involving cosmetic surgery to the contrary, services rendered to improve appearance (such as abdominoplasties, panniculectomies, and lipectomies), are not covered services even though the services may be required to correct deformity after a previous therapeutic process involving gastric bypass surgery.
- benefits for **organ or tissue transplants**, including complications caused by them, except when they are considered medically necessary, have received pre-authorization, and are not considered experimental/investigative. Autologous bone marrow transplants for breast cancer are covered only when the procedure is performed in accordance with protocols approved by the institutional review board of any United States medical teaching college. These include, but are not limited to, National Cancer Institute protocols that have been favorably reviewed and used by hematologists or oncologists who are experienced in high dose chemotherapy and autologous bone marrow transplants or stem cell transplants. This procedure is covered despite the exclusion in the plan of experimental/investigative services.

P

- **paternity testing**.

- **prescription drug benefit** does not include coverage for:

— birth control medications and devices;

— over the counter drugs;

— any per unit, per month quantity over the plan's limit;

— drugs used mainly for cosmetic purposes;

— drugs that are experimental, investigational, or not approved by the FDA;

— cost of medicine that exceeds the allowable charge for that prescription;

— drugs for weight loss;

— stop smoking aids;

— therapeutic devices or appliances;

— injectable prescription drugs that are supplied by a provider other than a pharmacy;

— charges to inject or administer drugs;

— drugs not dispensed by a licensed pharmacy;

— drugs not prescribed by a licensed provider;

— any refill dispensed after one year from the date of the original prescription order;

— medicine covered by workers' compensation, Occupational Disease Law, state or government agencies; or

— medicine furnished by any other drug or medical service.

• **private duty nurses** in the inpatient setting.

R

• rest cures, **residential** or domiciliary care and services. Whether care is considered residential will be determined based on factors such as whether the member receives active 24-hour skilled professional nursing care, daily physician visits, daily assessments, and structured therapeutic services.

• care from institutions that are licensed based solely as **residential treatment** centers, intermediate care facilities, or other non-skilled sub-acute inpatient settings.

S

• **services or supplies** if they are:

— ordered by a doctor whose services are not covered under your health plan;

— care of any type given along with the services of an attending provider whose services are not covered;

— not listed as covered under your health plan;

— not prescribed, performed, or directed by a provider licensed to do so;

— received before the effective date or after a covered person's coverage ends; or

— telephone consultations, charges for not keeping appointments, or charges for completing claim forms.

• **services or supplies** if they are:

— for travel, whether or not recommended by a physician;

— given by a member of the covered person's immediate family;

— provided under federal, state, or local laws and regulations. This includes Medicare and other services available through the Social Security Act of 1965, as amended, except as provided by the Age Discrimination Act. This exclusion applies whether or not you waive your rights under these laws and regulations. It does not apply to laws that make the government program the secondary payor after benefits under this policy have been paid. Anthem will pay for covered services when these program benefits have been exhausted;

— provided under a U.S. government program or a program for which the federal or state government pays all or part of the cost. This exclusion does not apply to health benefits plans for civilian employees or retired civilian employees of the federal or state government;

— received from an employer mutual association, trust, or a labor union's dental or medical department; or

— for diseases contracted or injuries caused because of war, declared or undeclared, voluntary participation in civil disobedience, or other such activities.

- **services** for which a charge is not usually made. This includes services for which you would not have been charged if you did not have health care coverage.

- **services or benefits** for:

— amounts above the allowable charge for a service;

— self-administered services or self care;

— self-help training; or

— biofeedback, neurofeedback, and related diagnostic tests.

- benefits for surgeries for **sexual dysfunction**. In addition, your coverage does not include benefits for services for **sex transformation**. This includes medical and mental health services.

- the following **skilled nursing** facility stays:

— treatment of psychiatric conditions and senile deterioration; or

— facility services during a temporary leave of absence from the facility.

- benefits for services related to **smoking cessation**, including stop smoking aids or services of stop smoking clinics.

- **spinal manipulations** or other manual medical interventions for an illness or injury other than musculoskeletal conditions.

T

- the following **therapies**:

— physical therapy, occupational therapy, or speech therapy to maintain or preserve current functions if there is no chance of improvement or reversal except for children under age 3 who qualify for early intervention services;

— group speech therapy;

— group or individual exercise classes or personal training sessions;

— recreation therapy. This includes, but is not limited to, sleep, dance, arts, crafts, aquatic, gambling, and nature therapy.

These services are not covered under your Anthem KeyCare plan.

V

- the following **vision services**:

— services for radial keratotomy and other surgical procedures to correct nearsightedness and/or farsightedness. This type of surgery includes radial keratoplasty and Lasik procedure;

— services for vision training and orthoptics; or

— any other vision services not specifically listed as covered.

W

- services or supplies if they are for **work-related** injuries or diseases when the employer must provide benefits by federal, state, or local law or when that person has been paid by the employer. This exclusion applies even if you waive your right to payment under these laws and regulations or fail to comply with your employer's procedures to receive the benefits. It also applies whether or not the covered person reaches a settlement with his or her employer or the employer's insurer or self insurance association because of the injury or disease.

The most detailed description of benefits, exclusions and restrictions can be found in the following group policies and endorsements which can be requested by calling Member Services at 1-800-451-1527 or 358-1551 from the Richmond calling area:

PP-INTRO (7/04), P-TOC (7/04), P-SB1 (7/04), P-SB2 (7/04), P-SB3 (7/04), P-SB4 (7/04), P-WORKS (7/04), P-COVERED (7/04), P-EXCL (7/04), P-CLAIMS (7/04), P-ENR (1/04), P-ENDS (1/04), P-INFO (7/03), P-RIGHTS (1/04), P-DEF (7/04), P-XH-A (7/04), P-ACC (3/00), P-INDEX (7/04)

Enrollment applications used for Anthem KeyCare:
490760 (4/04), 490760 (7/03), 490760,pdf (7/03), 490760 (4/03), 490760.pdf (4/03), 490773 (4/04), 490773 (7/03), 490773.pdf (7/03), 490773 (4/03), 490773.pdf (4/03), 490750 (4/03), 490751 (4/03), 490752 (4/03), 490753 (8/03), 490756 (4/03), AVA1143, AVA1144, AVA1145, AVA1146, 111578 (7/04)

This is not a contract or policy. This brochure is not a contract with Anthem Blue Cross and Blue Shield. It is a summary of benefits available through Anthem KeyCare offered by Anthem Blue Cross and Blue Shield. If there is any difference between this brochure and the group policy, the provisions of the group policy will govern.

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

For more information, please call Member Services at 1-800-451-1527 or 358-1551 from the Richmond calling area.

Visit us on the internet at www.anthem.com.

300679

PVA1681 (7/04)

Anthem Essential Plan and Anthem Standard Plan **Anthem Blue Cross and Blue Shield**

The Essential and Standard Benefit plans were developed by the Commonwealth of Virginia for the purpose of increasing access to health care for Virginia's small business owners and their employees. Developed exclusively for companies in the 2-50 eligible employee market, all health insurance companies and health maintenance organizations (HMOs) that offer coverage to this market in Virginia must offer similar plans that provide for the coverage of certain medical services and certain benefit levels, as defined by the Commonwealth.

Summary of Rates for Essential and Standard Plans

Based on the group's specific CMF and area:

Rates are also available for these plans without dental coverage. Call for details.	Essential Benefit Plan with Dental	Standard Benefit Plan with Dental
Employee		
< 29	$152.86	$160.80
30 to 39	$175.70	$184.82
40 to 49	$211.43	$222.41
50 to 59	$325.18	$342.06
60 >	$460.28	$484.18
Plus Child		
< 29	$244.11	$256.78
30 to 39	$263.46	$277.14
40 to 49	$297.69	$313.15
50 to 59	$413.19	$434.65
60 >	$557.87	$586.84
Plus Children		
< 29	$374.47	$393.93
30 to 39	$390.79	$411.10
40 to 49	$418.40	$440.15
50 to 59	$539.74	$567.79
60 >	$681.16	$716.56
Plus Spouse		
< 29	$374.36	$393.81
30 to 39	$411.38	$432.76
40 to 49	$457.09	$480.85
50 to 59	$647.24	$680.88
60 >	$897.73	$944.38
Plus Family		
< 29	$531.50	$559.11
30 to 39	$589.11	$619.72
40 to 49	$647.38	$681.01
50 to 59	$838.36	$881.91
60 >	$1,003.44	$1,055.57

Summary of Benefits for Essential and Standard Plans

Following is a partial outline of major benefits available through these plans, which are administered on a calendar year basis:

Annual deductible (the amount a member must pay each calendar year before the plan begins to pay benefits)	$500 per person $1,000 per family
Annual out-of-pocket expense limit per calendar year (does not apply to all services*)	$3,000 per person $6,000 per family
Lifetime maximum benefit limit	$1,000,000 per person
Outpatient Care • Doctors' office visits • X-rays, labs and diagnostic tests • Preventive care services • Hospital facility care (surgery, treatment of accidental injuries, emergency care) • Mental health and substance abuse care (limited to 20 visits per person per year) • Home health care (Standard plan only) • Occupational, physical and speech therapy (Standard plan only) • Audiology services, including hearing aids (Standard plan only) • Allergy testing and treatment (Standard plan only)	30% of allowable charges, after deductible (The *allowable charge* is an amount a participating provider has agreed to accept as payment in full for services rendered)
Inpatient Care • Medical, surgical and maternity admissions; ancillary services; semi-private room • Hospital care for mental health and substance abuse (limited to 21 days per year) • Hospice care (Standard plan only) • Skilled nursing home care (Standard plan only)	30% of allowable charges, after deductible
Prescription Drugs • Limited to generic drugs, unless a generic is not available (based on generic drugs approved by the Virginia Voluntary Formulary Board)	30% per prescription or refill
Vision Care • Standard Plan – covered for adults and children • Essential Plan – covered for children age 17 and younger only **Limited to one pair of lenses and frames per person per year*	30% of allowable charge, after deductible
Dental Services • Standard Plan – covered for adults and children • Essential Plan – covered for children age 17 and younger only **Routine exams and cleanings limited to 2 per person per year*	30% of allowable charge, after deductible

***The following do not count toward the out-of-pocket expense limits for covered services under these plans:**

1. Copayments for outpatient mental health and substance abuse
2. Copayments for outpatient prescription drugs
3. Copayments for dental services
4. Amounts above the allowable charge
5. Expenses for supplies or services not covered by the group policy
6. Amounts above plan limits

Anthem Essential Plan and Anthem Standard Plan
Anthem Blue Cross and Blue Shield

The Essential and Standard Benefit plans were developed by the Commonwealth of Virginia for the purpose of increasing access to health care for Virginia's small business owners and their employees. Developed exclusively for companies in the 2-50 eligible employee market, all health insurance companies and health maintenance organizations (HMOs) that offer coverage to this market in Virginia must offer similar plans that provide for the coverage of certain medical services and certain benefit levels, as defined by the Commonwealth.

Summary of Benefits for Essential and Standard Plans
Following is a partial outline of major benefits available through these plans, which are administered on a calendar year basis:

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Annual out-of-pocket expense limit per calendar year (does not apply to all services*)	$3,000 per person $6,000 per family
Lifetime maximum benefit limit	$1,000,000 per person
Outpatient Care ·Doctors' office visits ·X-rays, labs and diagnostic tests ·Preventive care services ·Hospital facility care (surgery, treatment of accidental injuries, emergency care) ·Mental health and substance abuse care (limited to 20 visits per person per year) ·Home health care (Standard plan only) ·Occupational, physical and speech therapy (Standard plan only) ·Audiology services, including hearing aids (Standard plan only) ·Allergy testing and treatment (Standard plan only)	30% of allowable charges, after deductible (The *allowable charge* is an amount a participating provider has agreed to accept as payment in full for services rendered)
Inpatient Care ·Medical, surgical and maternity admissions; ancillary services; semi-private room ·Hospital care for mental health and substance abuse (limited to 21 days per year) ·Hospice care (Standard plan only) ·Skilled nursing home care (Standard plan only)	30% of allowable charges,after deductible
Prescription Drugs ·Limited to generic drugs, unless a generic is not available (based on generic drugs approved by the Virginia Voluntary Formulary Board)	30% per prescription or refill
Vision Care ·Standard Plan - covered for adults and children ·Essential Plan - covered for children age 17 and younger only **Limited to one pair of lenses and frames per person per year*	30% of allowable charge,after deductible
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1. Copayments for outpatient mental health and substance abuse
2. Copayments for outpatient prescription drugs
3. Copayments for dental services
4. Amounts above the allowable charge
5. Expenses for supplies or services not covered by the group policy
6. Amounts above plan limits