Anthem®

KeyCare Flexible Choice℠
Essential KeyCare®
KeyCare Preferred®

Anthem Individual KeyCare Plans

A Benefit Guide to help you find affordable health care coverage that works for you.

916125 (11/06)

Welcome to Anthem Blue Cross and Blue Shield

Solutions for Individuals

Table of Contents

Your health is your most valuable asset. Without your health and the health of those you love other things in life aren't so important.

But the cost of medical care continues to rise. Routine medical care — the visits we plan for — are hard enough to manage. Without the right health insurance, unexpected medical expenses can be financially devastating.

Millions of Americans don't have health insurance through their work. Perhaps they are self-employed. Between jobs. Their employer doesn't offer health insurance. Whatever the reason, they need affordable solutions for individuals, so they can protect themselves and their families.

At Anthem, we are committed to finding those solutions. Solutions that make sense for individuals. Solutions that individuals can afford.

As you review this material, keep in mind that we're not just here to help you protect your financial future. We're here to help you protect your health, and the health of the people you love.

Did you know?

If you're self-employed, your individual health insurance premiums may be tax-deductible. Contact your financial advisor or visit **www.irs.gov** for details.

What is a KeyCare Plan?

The term KeyCare refers to Anthem Blue Cross and Blue Shield's KeyCare PPO (Preferred Provider Organization) network. KeyCare plans offer you the cost-savings of a PPO network. For more information about the KeyCare network, see The Benefits, page 4.

Your health is as individual as you are. **That's why we offer you choices.**

Each Anthem Individual KeyCare plan is designed with different health care needs and budgets in mind. And within each plan, you have a choice of deductibles, to help you find a premium that works for you.

Take care of your health!

All Individual KeyCare plans offer benefits for important routine wellness care, or preventive care services. We hope our members use them. Preventive care, along with other smart health care choices, helps keep the cost of health care and health insurance down for everyone.

Anthem Individual KeyCare Plans

KeyCare Flexible Choice:	Essential KeyCare:	KeyCare Preferred:
Sensible. Designed to move with you through your life. Offers a choice of additional benefits you can add or remove (for a change in cost), so you don't pay for optional coverage you don't need.	Affordable. Solid, basic protection that covers the essentials.	Comprehensive. Provides strong protection for families.
Offers: · A simple cost sharing design. All covered out-of-pocket expenses, except prescription drugs, apply to the expense limit · Predictable copayments for in-network doctor visits, before your deductible · Routine wellness doctor visits and screenings covered before the deductible · Drug benefits before the deductible	**Offers:** · Our lowest premium · Three doctor visits covered before the deductible. These visits may include routine wellness visits – the choice is yours	**Offers:** · Our lowest deductible option · Predictable copayments for in-network doctor visits, before your deductible · Routine wellness doctor visits and most screenings before the deductible · Preventive care and immunizations for children included before the deductible · Drug benefits before the deductible · Preventive dental benefits before the deductible
Consider: · Preventive care and immunizations for children available as a rider	**Consider:** · Other than the three doctor visits, all other benefits are provided after the deductible · There is a separate prescription drug deductible · Covers generic drugs only · Maternity rider is not available with this plan · Only coinsurance applies to your out-of-pocket expense limit	**Consider:** · KeyCare Preferred offers our most comprehensive benefits, so the premium is higher than our other plans. · Only coinsurance applies to your out-of-pocket expense limit

The Basics

The first section of your KeyCare Plan Benefit Summary is called "The Basics". This section describes how Anthem will share the cost of your health care with you.

The cost of health insurance (your premium) depends on the level of cost sharing between you and the health insurer. When you think about cost sharing, consider how you plan to use your benefits, and how much expense you could handle if you had unexpected medical bills. Remember, other than your Lifetime Maximum Benefit, cost-sharing is measured each calendar year.

Here are some important cost-sharing terms:

Coinsurance

The percentage of the allowable charge you pay for covered services. Your level of coinsurance depends on the deductible you choose. With larger deductibles, you pay more out of your pocket before your benefits begin, so your coinsurance is typically set at 0%.

Copayment, or Copay

A flat-dollar amount you pay for covered services.

Deductible

The amount you pay toward covered health care services each calendar year before receiving benefits. Choosing a higher deductible will lower your premium.

Deductibles apply to covered individuals. All three plans offer a family deductible option: once two or more covered persons meet two times the individual deductible, the family deductible is met. At that point, no other deductible has to be met for the family for the rest of the year.

Lifetime Maximum Benefit

The maximum amount we will cover during the lifetime of the policy for each covered person. If you change from one Anthem individual policy to another, this amount is carried with you from policy to policy.

Out-of-Pocket Expense Limit, or Expense Limit

The total amount you are responsible for paying out of your pocket for covered services.

Your annual out-of-pocket expense limit helps protect you from high dollar medical expenses by limiting what you pay for yearly covered health care expenses. It works differently depending on the plan you choose:

KeyCare Preferred and Essential KeyCare: After you pay your yearly deductible, your out-of-pocket expense limit helps to cap the total annual amount you spend on coinsurance. There are some coinsurance amounts you are always responsible for paying. Please see the out-of-pocket expense limit exclusions for KeyCare Preferred and Essential KeyCare listed in the back of this brochure.

KeyCare Flexible Choice: Your out-of-pocket expense limit helps control your yearly covered expenses. Your coinsurance, copayments and deductible are all applied to your expense limit. Please see the out-of-pocket expense limit exclusions for KeyCare Flexible Choice listed in the back of this brochure.

A Quick Look at Cost Sharing:

What's important to you?

	KEYCARE FLEXIBLE CHOICE	ESSENTIAL KEYCARE	KEYCARE PREFERRED
Maximum security? A lower deductible option	Yes. Offers a $500 option with basic benefits	Yes. Offers a $500 option with basic benefits	Yes. Offers a $300 option with rich benefits
Lower premiums? Higher deductible options	Yes.	Yes, because benefits are basic. Deductible options are not as high.	Higher premiums because of richer benefits.
Family deductible? (Family deductible = 2 x the individual deductible)	Yes.	Yes.	Yes.
A simple cost sharing design? Once you reach your out-of-pocket maximum for the year, your policy pays all other covered expenses.	Yes, except for prescription drugs	No.	No.

The Benefits

Anthem KeyCare Providers. Helping you stay healthy. Helping you save money.

With Anthem Individual KeyCare Plans, you save money by visiting doctors and hospitals in the Anthem KeyCare PPO (Preferred Provider Organization) network.

A big part of the KeyCare network savings is Anthem's **allowable charge**, or the allowance Anthem will pay for covered services. Our allowable charge is often less than the provider's normal charge. KeyCare providers (hospitals, doctors, and other medical providers in the KeyCare PPO network) agree to accept Anthem's allowable charge as payment in full.

How does this save you money? With a KeyCare provider, any coinsurance amount you owe is a percentage of our allowable charge — which reduces your share of the cost. Haven't met your deductible yet? With a KeyCare provider, you are only responsible for paying Anthem's allowable charge — **so you save money even before your benefits begin.**

Flexibility

With Anthem KeyCare PPO plans, you can visit providers outside the KeyCare network and still have benefits. However, your share of the cost for covered services will increase.

Outside the network, you will be responsible for:

- a separate deductible and out-of-pocket expense limit,
- a higher coinsurance amount, and
- any difference between Anthem's allowable charge and the provider's actual charge.

In addition, providers outside the KeyCare PPO network may not file your claims for you.

In most cases, KeyCare providers will file your claims for you, saving you time, hassle, and postage costs[1].

[1] Automatic claims filing is a value-added service and is not part of nor guaranteed by the policy, and can be modified or discontinued at our discretion.

Hospital Inpatient and Outpatient Care, and Emergency Care

Benefits work the same for all the plans. You pay a coinsurance amount after your deductible.

Emergency Care

If you need emergency care, you should go to the closest doctor or hospital available. If it is a true emergency, you will receive in-network benefits even if the provider is not in the KeyCare network. Anthem considers Emergency Care to be services and supplies for emergency treatment of traumatic bodily injuries resulting from an accident or a sudden onset of a life-threatening medical condition. Emergencies include cardiac arrest, appendicitis, heat stroke, or other severe medical conditions.

Doctor Visits

Coverage for doctor visits varies between plans. With KeyCare Flexible Choice and KeyCare Preferred, you pay a set amount, or copayment, before the deductible. With Essential KeyCare, this is limited to the first three yearly doctor visits per person, then you are responsible for a coinsurance amount after your deductible.

What's important to you?

	KeyCare Flexible Choice	Essential KeyCare	KeyCare Preferred
Doctor Visits before deductible?	Yes, unlimited.	First 3 visits per person, before deductible, sick or routine.	Yes, unlimited.
Routine wellness visits covered before deductible?	Yes.	If part of the first 3 visits.	Yes.
Predictable Copayment?	Yes.	If part of the first 3 visits.	Yes.

Routine Wellness

For routine care, you share the cost for the following types of services:

The office visit

Routine wellness doctor office visits are covered starting at age 7.

The screenings

Screenings include:

(1) simple procedures, such as lab work, x-rays and immunizations, and

(2) more complicated, costly procedures, such as cancer screenings.

Preventive Care Services Include:

Service/Screening	Age	Frequency
Pap Smear	Any age	1 per year
Mammography	35 & older	
Prostate (PSA)	50 & older (40 – 49 if high risk)	
Colonoscopy	As recommended by the American College of Gastroenterology & the American Cancer Society	

What's important to you? Adult Preventive Care

	KeyCare Flexible Choice	Essential KeyCare	KeyCare Preferred
Routine doctor visits per person, per year	2	1	2
Covered before deductible?	Yes.	If part of the first 3 visits per year.	Yes.
Screenings covered before the deductible?	Yes.	No.	Yes, except for colorectal cancer screenings
Extra $150 for routine labwork, x-rays & immunizations	Yes.	No.	Yes.

Preventive Care & Immunizations for Children

KeyCare Preferred includes preventive care benefits for children from birth through age six. These benefits are easy to use — services are covered at 100% in or out-of-network. No deductible, no copayment or coinsurance.

A specific list of covered services can be found on **anthem.com**.

They include:

- Office visits
- Lab tests
- Vision and hearing screenings
- Immunizations

KeyCare Flexible Choice and Essential KeyCare cover routine childhood immunizations from birth to 36 months. For additional benefits like the ones described for KeyCare Preferred, you can purchase our optional coverage Preventive Care and Immunizations for Children.

Prescription Drugs

The cost of prescription drugs can be staggering. In fact, prescription drug costs are one of the leading drivers of rising health care costs. Helping control those costs is key to providing affordable health care and health insurance to everyone.

All KeyCare plans provide up to $5000 per person in yearly prescription drug benefits. KeyCare Flexible Choice covers specialty drugs beyond that limit. See your Benefit Chart for more details.

Save With Generics

You get the best value when you choose generic drugs when available. The cost-sharing design for each plan is different, to help you find a prescription drug benefit that best fits your needs and budget.

A Note About KeyCare Flexible Choice

With KeyCare Flexible Choice, prescription drug benefits are divided into two categories, or tiers: Non-specialty, or Tier 1 drug benefits, and Specialty, or Tier 2 drug benefits. Your Benefit Comparison Chart gives more details.

What is a Specialty drug?

Specialty drugs are high cost, scientifically engineered drugs. They are usually injected or infused and require special storage and handling that make them difficult for a typical pharmacy to dispense. Certain Specialty drugs are only available through Anthem's Specialty Pharmacy Network, PrecisionRx Specialty Solutions. If you enroll in KeyCare Flexible Choice, you'll receive more information in your member kit.

What's important to you? Prescription Drug Coverage

	KeyCare Flexible Choice	Essential KeyCare	KeyCare Preferred
Benefits before the deductible?	Yes.	No. Separate $200 drug deductible.	Yes.
Benefits for generic and brand?	Yes. You pay less for generics.	No. Generic only.	Yes. You pay less for generics.

Benefits available at an additional cost

Why pay extra for benefits you won't use? We offer optional coverage that you can add to your plan for an additional cost, to help you find coverage that best fits your life today, and tomorrow.

Maternity

KeyCare Flexible Choice & KeyCare Preferred

If you're hoping to add to your family in the future, you may want to think about adding maternity coverage now. Conception must occur at least six months after the effective date of this coverage, even if you qualify for credit toward your base policy's 12 month pre-existing waiting period. Pregnant women who are HIPAA "eligible individuals" may not have to wait six months. Your enclosed Anthem application defines HIPAA-eligible individuals. Your Anthem Sales Representative will have more information.

Note: Maternity coverage cannot be added to a policy insuring one male without a female spouse or female domestic partner on the policy, or for female applicants under age 18 unless they are emancipated minors.

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 and
- diagnostic x-rays and lab charges.

Supplemental Accident Coverage

All KeyCare plans provide emergency care benefits, but the unexpected costs of an accident can still add up. With each KeyCare plan in this brochure, you can purchase Supplemental Accident Coverage to help you with these costs. In order to make the most of your KeyCare benefits, you'll still need to visit a KeyCare network provider. If you visit a provider outside the KeyCare network, your share of the costs for covered services may increase. Supplemental Accident Coverage benefits are available before any deductible.

With Essential KeyCare & KeyCare Preferred:

- Anthem pays 100% of the allowable charge, up to $500 per accident

With KeyCare Flexible Choice:

- Anthem pays 100% of the allowable charge, up to a total of $750 per person, per year

Preventive Care & Immunizations for Children Coverage

Available with KeyCare Flexible Choice & Essential KeyCare *(These benefits included with KeyCare Preferred.)*

KeyCare Flexible Choice and Essential KeyCare only cover childhood immunizations from 0 – 36 months. This optional coverage extends those benefits to cover complete physical examinations and other benefits described on page 6.

What if I want to add (or delete) optional coverage later?

Generally, you can add or delete optional coverage on your policy's anniversary date, or when you experience a major life change, including marriage, divorce, legal separation, birth of a child, adoption, death, adding or deleting a dependent, or entering the military.

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? Protect your smile — and your health — with dental coverage.

KeyCare Flexible Choice & Essential KeyCare:
Dental Coverage provides preventive, restorative and complex care.

KeyCare Preferred:
Dental Coverage provides restorative, and complex care. Preventive care is included in base policy.

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**.

PREVENTIVE CARE (Included with Individual KeyCare Preferred)

COVERED SERVICES	WAITING PERIOD	COINSURANCE		DEDUCTIBLE		MAXIMUM COVERED PER YEAR
		IN NETWORK	OUT-OF NETWORK	IN NETWORK	OUT-OF 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 for covered persons age 5 and over)						
Preventive (includes cleanings, topical fluoride treatments for children under 16, space maintainers for children under 12)						

RESTORATIVE AND COMPLEX CARE

COVERED SERVICES	WAITING PERIOD	COINSURANCE		DEDUCTIBLE		MAXIMUM COVERED PER YEAR
		IN NETWORK	OUT-OF NETWORK	IN NETWORK	OUT-OF NETWORK	
Restorative Services (fillings)	6 months	50%	50%	$50/ 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 abscess)	18 months					
Prosthodontic Services (includes onlays, crowns, dentures)						
Endodontic Services (root canals)						
Periodontal Services (includes periodontal cleaning, scaling, and root planing)						

Policy Terms

The following are provisions to our policies, which outline specific requirements and procedures about our plans. However, keep in mind that this brochure is not your official policy. The policy you receive when you enroll in a plan will be a legal document that overrides any other descriptions of your coverage. Be sure to read it.

Eligibility

Anthem Blue Cross and Blue Shield Individual Coverage is available only to those who:

- reside in the Anthem Blue Cross and Blue Shield service area;* reside in the KeyCare service area;
- qualify medically and meet certain life-style criteria;
- are under age 65;
- are not entitled to Medicare benefits;
- do not currently have individual protection that provides similar benefits, unless Anthem's individual coverage will replace existing coverage; and
- are not on active duty with any branch of the Armed Services.

Eligible children must also be:

- unmarried; and
- under age 23

To be eligible for coverage as a domestic partner, you:

- must have been living together six or more months and plan to continue living together;
- are financially inter-dependent;
- are at least 18 years old; and
- are not married to anyone else and are not related by blood in a way that would prohibit marriage.

You, your spouse or domestic partner and dependent children are not eligible for this coverage if any person to be covered has been enrolled in an Anthem group plan within the last 64 days of the effective date of this individual plan. If you are a retiree and your employer does not contribute to you or your dependent's coverage, you, your spouse or domestic partner and dependents are eligible to apply.

Renewability

Your coverage is automatically renewed as long as:

- premiums are paid according to the terms of your policy;
- the insured lives, works, or resides in our service area;* and
- there are no fraudulent or material misrepresentations on your application or under the terms of your coverage.

We can refuse to renew your policy if all policies of the same form number are also not renewed. Any such action will be in accordance with applicable state and Federal laws.

Premium

We determine premiums based on such factors as age, sex, type and level of benefits, membership type, health, lifestyle and area of residence. These premiums are set by class. You will never be singled out for a premium change. Your premium may be adjusted periodically. We will give you prior written notice of any premium change we initiate.

Employer payment of premiums

The policies described in this brochure are individual health insurance policies, and, as such, cannot be used as employer-provided health care benefit plans. No employer of any covered person under these policies may contribute to premiums directly or indirectly, including wage adjustments. As it pertains to this section, an employer does not include a trade or business wholly owned by an individual or individual and spouse or domestic partner that has no other employees or that does not offer health benefits to any other employees. Also, as it pertains to this provision, a church may purchase an individual policy if only purchasing it for one employee.

Termination

Coverage ends for all persons insured under the policy if the insured dies. A covered person or guardian of a covered person must contact us to arrange for continued coverage in this instance.

Covered dependent coverage ends under these circumstances:

- for a covered spouse upon divorce from the covered person in whose name the policy was obtained;
- when a covered dependent begins active duty with the Armed Services;
- death of the dependent; or
- at the insured's request.

If a covered child is incapable of earning a living because of a mental or physical handicap that began before age 23, we will continue to cover the child as long as the policy is in force.

Cancelling your policy

If you wish to cancel your Anthem policy, you must call or notify us in writing. Any premium paid beyond your cancellation date will be refunded to you promptly after the cancellation.

Limited Benefit Policy

Our KeyCare plans are "limited benefit policies," meaning that there are times when you may be responsible for more than the 25% maximum coinsurance set by insurance regulations for major medical coverage. This happens only when your copayment or coinsurance is greater than the 25% coinsurance, or when you use an out-of-network provider.

** If you are an "Eligible Individual," as defined on the application, then coverage is available to you if you live, work or reside in our service area, (or the KeyCare service area if applying for a KeyCare plan).*

What's Not Covered

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

EXCLUSIONS:
Our KeyCare Flexible Choice, KeyCare Preferred and Essential KeyCare policies do not cover:

Pre-existing conditions
A pre-existing condition is any medical condition you had in the 12 months before your "effective date," or the date you are officially covered by the new policy. During the first 12 months after your effective date, the plans in this brochure do not cover prescription drugs prescribed for a pre-existing condition, services for, or complications resulting from, a pre-existing condition.

The waiting period for pre-existing conditions may be shorter, or waived, if you're transferring your coverage from a qualifying health plan.

Preventive care services
The policy only covers preventive care specified in the policy. It does not cover routine physical examinations, routine laboratory tests or routine x-rays that exceed what is specifically provided for in the policy.

Services not medically necessary
Services or care that are not medically necessary as determined by us, in our sole discretion.

We cover only medically necessary services in order to keep everyone's premiums down and to make sure services are provided in a safe, approved setting. Our licensed medical staff uses careful guidelines based on accepted medical practice to determine whether a service is medically necessary. These guidelines apply to everyone. You can find out whether a particular service or procedure is medically necessary and covered before you receive it, by calling us when you're considering treatment options with your physician. We'll work with you to find the safest and most effective treatment.

Services that are deemed experimental or investigative
Services that we deem, in our sole discretion, to be experimental/investigative, 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 and prescription drugs prescribed for or related to artificial insemination or in vitro fertilization or any other types of artificial or surgical means of conception. We also do not cover reversals of sterilization which resulted from a previous elective sterilization.

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

Hearing services
Implantable or removable hearing aids, including exams for prescribing or fitting hearing aids, regardless of the cause of hearing loss, with the exception of cochlear implants.

Vision services
Services for, or related to, procedures performed on the cornea to improve vision, in the absence of trauma or previous therapeutic process. Medical or surgical procedures to correct nearsightedness, far-sightedness, and/or astigmatism.

Foot care
Services for palliative or cosmetic foot care.

Cosmetic services
All medical, surgical, and mental health services for or related to cosmetic surgery and/or cosmetic procedures, including any medical, surgical, and mental health services to correct complications of a person's cosmetic procedure. Body piercing and cosmetic tattooing are considered cosmetic procedures. "Cosmetic surgery," however, does not mean reconstructive surgery incidental to or following surgery caused by trauma, infection, or disease of the involved part. We determine, in our sole discretion, whether surgery is cosmetic or is clearly essential to the physical health of the patient.

Certain types of therapies
Therapy primarily for vocational rehabilitation; certain drugs and therapeutic devices, including over-the-counter drugs and exercise equipment; outpatient services for marital counseling, coma-stimulation activities, educational, vocational, and recreational therapy, manual medical interventions for illnesses or injuries other than musculoskeletal illnesses or injuries.

What's Not Covered

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.

Any loss resulting from the covered person being under the influence of alcohol, intoxicants, illegal substances, or any prescription drug (unless the prescription drug is taken on the specific advice of a physician in a manner consistent with the advice).

Services provided by family or co-workers
Services performed by your immediate family or by you; services rendered by a provider to a co-worker 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; and
- 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 if they are for dates of service before the effective date or after a covered person's coverage ends.
- Telephone consultations, charges for not keeping appointments, or charges for completing forms or copying medical records.
- Services not specifically listed or described in this policy as covered services.
- Services to treat sexual dysfunction, including services for or related to sex transformation, when the dysfunction is not related to organic disease. This includes related medical services and mental health services.
- Complications of non-covered services — these services would include treatment of all medical, mental health and surgical services related to the complication.
- Services or supplies ordered by a physician whose services are not covered under the policy.
- Self-help, training, and self-help administered services.
- Manual medical interventions for illnesses or injuries other than musculoskeletal illnesses or injuries.

Out-of-pocket expense limit exclusions
The following items never count toward your out-of-pocket expense limit for KeyCare Preferred and Essential KeyCare:
- amounts we apply to your deductible;
- any coinsurance limitations listed on page X;
- amounts exceeding the allowable charge;
- expenses for services not covered under the policy; and
- copayments.

The following items never count toward your out-of-pocket expense limit for KeyCare Flexible Choice:
- amounts paid for prescription drugs, including specialty drugs and insulin;
- amounts exceeding the allowable change, and
- expenses for services not covered under the policy.

What's Not Covered

Optional Coverage exclusions

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

Dental Coverage exclusions

This Coverage does 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);
- sedative fillings; root canal therapy on other than permanent teeth; pulp capping (direct or indirect);
- separate charges for pulp vitality tests and bases and liners under restorations;
- therapeutic pulpotomy on other than primary teeth;
- guided tissue regeneration, including flap entry or re-entry and closure;
- gingival curettage;
- separate charges for irrigation or re-evaluation following periodontal therapy;
- periodontal splinting and occlusal adjustments for periodontal purposes;
- controlled release of medications to tooth crevicular tissues for periodontal purposes;
- repositioning appliances or restorations necessary to increase vertical dimensions or restore or correct the occlusion;
- services rendered for purposes other than to eliminate oral disease and/or replace covered missing teeth (mouth rehabilitation);
- gold foil restorations;
- inlays;
- temporary dentures or temporary crowns, or duplicate dentures;
- services to replace teeth that were lost or extracted prior to the rider's effective date;
- services to replace non-functioning teeth;
- fixed bridges when done in conjunction with a removable appliance in the same arch;
- precision attachments for dental appliances;
- tissue conditioning;
- prefabricated resin crowns;
- dental implants and associated services in conjunction with implants;
- consultations (including telephone consultations), charges for failure to keep a scheduled visit, charges for completion of a claim form, or charges for providing information in connection with a claim;
- occlusal guards and athletic mouth guards;
- bleaching or whitening of discolored teeth;
- behavior management or hypnosis;
- therapeutic injections;
- orthodontic services;
- separate charges for infection control procedures and procedures to comply with Occupational Safety and Health Administration (OSHA) requirements;
- analgesics (nitrous oxide);
- occlusal analysis;
- tooth desensitizing treatments; and
- When coverage is available for the following services, these services require the performance of diagnostic x-rays six months prior to the earlier of (1) the request for predetermination of such services or (2) the date the services were rendered:
  - more than one (1) crown;
  - fixed prosthetic devices; or
  - surgical extraction of impacted teeth.

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

Maternity coverage exclusions

(does not apply to Individual Essential KeyCare)

Maternity coverage covers pregnancies that begin at least six months after the rider becomes effective. Maternity and pregnacy-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. Call your Anthem Sales Representative for more details.

Supplemental accident coverage exclusions

The supplemental accident coverage covers ambulance services related to accidents.

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 KeyCare Flexible Choice, the optional coverage does not cover insulin and other prescription drugs, including specialty drugs, as they are covered under the base policy.

Preventive care & immunizations for children exclusions

Applies to Individual Essential KeyCare and KeyCare Flexible Choice only as this benefit is included under KeyCare Preferred. 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:

Benefit	Limit Per Calendar Year
· ground ambulance services	$3,000
· durable medical equipment	$5,000
· early intervention services (up to age 3)	$5,000
· manual medical interventions (spinal manipulation)	$500
· outpatient physical therapy and/or occupational therapy	$2,000
· outpatient speech therapy	$500
· home health care services	90 visits
· mental health & substance abuse services	20 outpatient visits; 25 inpatient days. Up to 10 inpatient days may be exchanged for 15 partial days. (1 inpatient day = 1.5 partial days.)
· skilled nursing facility stays	100 days

Prescription Drugs (non-specialty drugs)

· Prescription Drugs	$5,000
· Dispensed at Pharmacy	Up to a 34 day supply, or no more than 150 units per prescription, which ever is less.
· Ordered through the Home Delivery Pharmacy Service	Up to a 90 day supply per prescription.

Coinsurance limitations

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

For KeyCare Preferred and Essential KeyCare:
- coinsurance paid to a non-participating facility;
- coinsurance for manual medical interventions, including spinal manipulation;
- coinsurance and copayments for prescription drugs and insulin;
- coinsurance for Routine Wellness Care, except mammography screenings for ages 35 and older, and colorectal cancer screenings;
- coinsurance for outpatient mental health visits;
- coinsurance for outpatient physical therapy, outpatient speech therapy, outpatient occupational therapy, durable medical equipment, early intervention services and home health care services;
- coinsurance for skilled nursing facility stays; and
- coinsurance for dental services received out-of-network. (applies only to Individual KeyCare Preferred).

For KeyCare Flexible Choice:
- coinsurance and copayments for prescription drugs and insulin, and
- coinsurance for outpatient mental health visits 6-20.

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 a least 2 years from the time sealants are placed and the time a restoration is performed on the same tooth and surface for benefits to apply

Restorative
- 1 amalgam or resin restoration (filling) per tooth per surface: 1 per calendar year. White-colored composite resin fillings will only be covered on anterior (front) teeth. If composite resin filings are done on back teeth, then you are responsible for the difference between our allowable charge and the dentist's charge for amalgam filling restoration
- 1 pin retention per tooth per calendar year
- 1 stainless steel crown on each primary (baby) tooth: 1 each per lifetime

Endodontics
- Root canal; (anterior, bicuspid or molar) : 1 per tooth every 3 calendar years
- Retreat of previous root canal; (anterior, bicuspid, or molar): 1 per tooth per lifetime
- Apicoectomy/periradicular surgery; (anterior, bicuspid, molar, or additional root) : 1 per root or tooth per lifetime
- Retrograde filling: 1 per root or tooth per lifetime
- Root canals are covered only on permanent teeth:
- Therapeutic pulpotomy are covered only on primary (baby) teeth

Periodontics

- Periodontal cleaning (applies to your 2 cleanings per year): 1 per calendar year
- Periodontal scaling and root planing: 1 per quadrant every 2 calendar years
- Gingivectomy or gingivoplasty: 1 per quadrant every 3 calendar years
- Periodontal osseous (bone) surgery: 1 per quadrant every 3 calendar years
- Full mouth debridement: 1 per lifetime

Prosthodontics

- Services for bridges, crowns, and dentures are only covered for teeth extracted or missing after the rider's effective date, which includes initial placement, unless for an existing bridge more than 5 years old
- Adjustment or repair to partial or complete dentures: 1 per calendar year
- Chairside relining of partial or complete dentures: 1 every 2 calendar years
- 1 only, crown or bridge per tooth every 5 calendar years
- 1 partial or complete denture every 5 calendar years
- 1 laboratory rebasing or relining of dentures every 5 calendar years
- 1 crown repair per tooth per lifetime
- 1 crown recementation per tooth per lifetime

Oral Surgery

- Use of anesthesia only in conjunction with surgical procedures
- 1 vestibuloplasty every 3 calendar years

Adjunctive

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

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.

Important Information You Should Know

We're Committed to Your Privacy

As technology and communication capabilities continue to expand each year, so have concerns about the accessibility of private information. At Anthem, we take your privacy very seriously. The following is a brief outline of the steps we've taken to keep your information safe.

The confidentiality of your medical records is not just protected by law; Anthem goes beyond the law's requirements to ensure your privacy. We require all our employees to sign confidentiality statements keeping your records private. We also contractually require participating health care professionals to keep your medical records confidential. Any medical information we receive on your behalf — to help process your claims, for example — is kept secure and access to this information is limited to approved employees. And for added protection, our offices have employee security systems that tightly control access.

When claims data is used in measurement and quality reporting, everyone involved in the analysis signs a confidentiality agreement and findings are reported in ways that do not identify individual patients.

The Virginia Insurance and Privacy Protection Act prohibits the disclosure of personal, privileged or confidential information by an insurer to another party without written authorization from the individual. The law recognizes, however, that in a limited number of situations, an insurer may need to release confidential information without written authorization in order to administer benefits — coordinating care between your primary care physician and your specialist, for example. When your authorization is required, we will not release any information until we receive your (or your legal representative or guardian's) written permission.

An Extra Measure of Coordination and Support

Our plans have several programs and features in place to help coordinate your care as an extra measure of support for you and your family.

These programs include:

Admission Review, which is required before all hospital admissions, (except for maternity admissions without complications). Admission Review ensures that you or your family members are receiving the most appropriate care, in the most appropriate setting. Anthem must approve a hospital admission in order for you to receive benefits for that stay.

Network physicians will arrange for Admission Review approval on your behalf. However, if you are treated by a non-network provider, you are responsible for making sure the doctor obtains Admission Review approval. We will respond within 24 hours after notification, unless we need more information to make a decision. For emergency inpatient services, your doctor, you or a family member must contact us within 48 hours of the admission or on the next business day.

Concurrent Review and Discharge Planning, which helps assess the ongoing need for inpatient care and helps plan for the patient's treatment after discharge. Individual Case Management, a program designed to assist the planning of ongoing care for patients with a catastrophic illness or injury. This service helps our customers coordinate their medical services and/or equipment.

PRESCRIPTION DRUG BENEFITS

Here are some important facts about our prescription drug benefits:

Prior Authorization

We require prior authorization, or advance approval, for certain prescription drugs, or for quantities that exceed the amount ordinarily prescribed or ordered.

To obtain coverage for drugs requiring prior authorization, your physician will need to send a written request along with a copy of applicable medical records. If you choose to purchase these and certain other medications without first getting approval, you will have to pay the full cost. You can find out more about the prior authorization process, including a full list of drugs that require prior authorization, by calling your Anthem Sales Representative.

Generic vs. brand name drugs

Generic Drugs are a cost-saving alternative to brand name drugs. They are regulated by the Federal Drug Administration (FDA), and contain the same active ingredients in the same dosage as the original brand name product.

With Individual KeyCare Preferred, KeyCare Flexible Choice and Individual Essential KeyCare, you will receive the highest level of benefits by asking your physician to prescribe a generic drug whenever possible. If you choose to purchase a brand name drug when a generic drug is available, you will be responsible for the difference in cost between brand and generic, plus your copayment or coinsurance.

With Individual Essential KeyCare, you must purchase generic drugs in order to receive prescription drug benefits. If you choose a brand name drug, you'll have to pay the entire cost of the prescription; however, if you choose a participating pharmacy and present your identification card, you'll be responsible for 100% of Anthem's allowable charge, which is usually lower than the total cost of the drug.

Sometimes physicians prescribe medications to be dispensed as written when there are generic alternatives available. To help save money, network pharmacists may discuss with those physicians whether an alternative drug might be appropriate. Physicians always make the final decision on the medications they prescribe.

Coordination of Benefits

If you choose to be covered by two or more types of health insurance, it's important to know our Coordination of Benefits procedures.

Anthem Blue Cross and Blue Shield policies all have a coordination of benefits provision. This provision explains that if you are issued an Anthem Blue Cross and Blue Shield individual policy, and one of the persons covered by your Anthem policy is covered by a group health plan, the group health plan will have primary responsibility for the covered expenses of that family member.

For any dependent children on your Anthem individual policy who are enrolled under another individual health plan, the primary policy is the policy of the parent whose birthday (month and day) falls earlier in the calendar year. Parent birth year is not considered.

This is not your policy and is intended as a brief summary of services. If there is any difference between this brochure and the policy, the provisions of the policy shall control. This brochure is only one part of your entire fulfillment kit. This brochure refers to Policy Form #s 901119-CP.1 et al., Schedule of Benefits Form #s AVA1513, PVA1723, 901152 or PVA2326, and Application Form #s AVA1529, AVA1533, AVA1536, AVA1313 or AVA1537, AVA1359, or AVA1572, and Rider Form #s 901165, AVA1392, AVA1393, 901167, AVA1517, and AVA1347.

Questions?
For more information about Anthem Individual KeyCare Plans, contact your Anthem Sales Representative. Or, for more information, please visit our Web site at **www.anthem.com**.

For more information, visit our Web site at anthem.com

Anthem®

Our service area is Virginia, excluding the city of Fairfax, the town of Vienna, and the area east of State Route 123.
Anthem's KeyCare PPO Network is only available in certain parts of Virginia.

Important Information About Your Personal Health Care Coverage

We recently changed the names of special services or clarified certain issues pertaining to your Anthem Blue Cross and Blue Shield health care coverage.

Unless otherwise noted, the following changes are effective as of July 1, 2007:

Pharmacy Name Change

In January 2007, our mail order pharmacy changed its name to WellPoint NextRx. The new name reflects Anthem's efforts to integrate our pharmacy companies and bring you quality service. While the name has changed, everything else remains the same, including your prescription drug benefits, phone numbers, web sites, hours of operation, current support resources, and the delivery of benefits and service.

Our mail service pharmacy is specifically designed for members who take maintenance medications on a regular basis for longer periods of time. This includes medications used to treat chronic conditions such as high cholesterol, diabetes, high blood pressure, arthritis, or depression, as well as medications used on a regular basis, such as oral contraceptives. You can learn more about our mail service pharmacy by visiting our Web site at:

Anthem.com > Members > Virginia >Plans and Benefits > Prescription >Mail Service Pharmacy

---

Special Program Name Changes

We've changed the names of some of our special programs that are added features but not an actual part of your policy or benefits. These added features can be modified or discontinued at our discretion. Here are the new names effective July 1, 2007:

Previous Name		New Name
Baby Benefits	=>	Future Moms
Better Prepared	=>	ConditionCare

Alcohol Exclusion Removed

We have removed the exclusion regarding alcohol, intoxicants and illegal substances from your health care contract. However, all other limitations and exclusions continue to apply. This change affects services for dates of service of July 1, 2007 and after.

New Application Form Numbers

Some of our application form numbers have changed. The new application form numbers are: AVA1647, AVA1628, AVA1631, AVA1663, AVA1648, AVA1629, AVA1632, AVA1664, AVA1649, AVA1630, AVA1633, AVA1665, AVA1634, AVA1635, and AVA1660

AVA1667