

Anthem BlueCare

Health Care Plans for Small Businesses

At Anthem Blue Cross and Blue Shield, we understand that health insurance is one of the major expenses for a small business. We also understand how tough it is to keep good employees without good benefits. That's why we provide a variety of plan options, so you have some flexibility to customize your coverage for your business needs.

What Does an Anthem BlueCare Plan Give You?

A Choice of Copayment or Deductible Plans

Most group health plans are typically either a copayment or a deductible plan. Anthem offers both types to choose from. The difference is in the way members share the costs with the health plan. Generally speaking, the more of the costs our members can afford to share, the lower the premiums.

Deductible plans require the member to pay a specified amount each calendar year, depending on the plan option chosen, before the insurance company begins to pay for covered services. This amount is called the “annual deductible.”

After the annual deductible is met, members pay 20% of the amount participating health care professionals have agreed to accept for services such as check-ups, sick visits, labs, and x-rays.

With a **copayment plan**, members generally pay a flat, fixed amount, called the “copay” or “copayment,” whenever they visit the doctor.

With both types of plans, members pay a “coinsurance” (a percentage of the costs) for certain services after meeting any required deductible.

Coverage for:

- Office visits
- Labs, x-rays and other types of tests
- Well baby visits, including recommended immunizations and tests
- Emergency and urgent care
- An annual routine eye exam
- Maternity visits before and after having a baby
- Care in a hospital
- Health care services when and where the member needs it, at home, or on the road through the BlueCard® program
- Access to the 24/7 NurseLine — Health concerns don't follow a 9 to 5 weekday schedule. Our 24/7NurseLine is available 24 hours a day 7 days a week. Members can speak with a qualified registered nurse for guidance on a range of conditions.
- Access to ConditionCare — an ongoing care management program to help members coordinate treatment and support for chronic medical conditions, such as asthma, and stay up to date on the latest information

Plus, access to discounts* on:

- Health and wellness products
- Fitness clubs and health centers
- Alternative medicine service, such as acupuncture, chiropractic and massage therapy
- Vitamins and nutritional supplements

- Eyewear and supplies
- Laser vision correction surgery
- Cosmetic dentistry
- Smoking cessation

** These added features and discount programs are not a part of the policy. They are not guaranteed by your policy and can be modified or discontinued at our discretion.*

No Network Restrictions

Our BlueCare plans are traditional fee-for-service plans that give members the freedom to pick most any licensed doctor, hospital or pharmacy for health care services, without network restrictions. Furthermore, members can coordinate their own care and do not need referrals from their primary doctor to see other physicians or specialists.

With these plans, however, there are “participating” providers who agree to accept our set fees, called *allowable charges*, as payment in full for covered services, while “non-participating” providers can charge whatever they want for the same services. Because of our cost-saving agreement with them, “participating” providers are often referred to as “in-network,” while “non-participating” providers are generally considered “out-of-network.”

Of course, BlueCare members are free to visit any out-of-network health care professional they choose, however, their costs usually will be greater. That's because a non-participating provider can charge more than our set fee for a service, and if so, then the member is responsible for paying the difference in cost.

Aside from the cost savings, using participating providers has other advantages. In most cases, they also will file claims and handle any necessary authorizations for members.

To receive an annual eye exam for \$15, members need to use an eye care professional in the Blue View Vision network. Again, BlueCare members are free to use eye care professionals outside of the Blue View network for the annual routine eye exam. If the member goes to an eye care professional not in the Blue View Vision network, Anthem's allowance is \$30, and the member will pay the rest of what the eye professional charges.

Blue Advantage

We're also pleased to offer **Blue Advantage**, which provides small group employers more options in designing their health care program. Here's how it works: at the group's renewal, employers with **at least 5** employees electing coverage may select two health care plans to offer — giving their employees more freedom to choose the health care plan that best suits their individual needs. Your broker or Anthem sales representative can tell you what product pairings are available in your area.

Other Health Plans Available

Depending on where you are located, some of our other products may be available to you. These may include Anthem HealthKeepers, our HMO (health maintenance organization) product line, or Anthem KeyCare, which offers flexible plans with cost-saving agreements through a PPO (Preferred Provider Organization) network.

We also offer Essential and Standard Benefit Plans developed by the Commonwealth of Virginia for the purpose of increasing access to quality 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 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.

If you would like information about other health plans, or for more details about the benefits summarized in this brochure, please contact your agent or sales representative, call our Small Group Sales Department at **1-800-543-8919**, or visit the Benefit Manager's page on our Web site at: www.anthem.com

Important Terms

Here are some important definitions to know as you review the benefit charts on the following pages:

Annual Deductible

Amount a member pays toward covered services each calendar year before receiving certain benefits.

Family Deductible = 2x per person amount

Copayment

A fixed dollar amount a member pays for certain services such as doctor's visits.

Coinsurance

A percentage a member generally pays for certain covered services, such as outpatient X-rays, tests, outpatient surgery, emergency care, and inpatient care, after the member has paid any applicable copayment or deductible.

Annual Out-of-Pocket Expense Limit

This expense limit helps protect members from high dollar medical costs. After paying the yearly deductible, the out-of-pocket expense limit helps to cap the total amount a member is responsible for paying each benefit period. Please see the Limitations for Out-of-Pocket Expenses in this brochure. Family Expense Limit = 2x per person amount.

Important Notes About These Plans:

Refer to the benefit charts for related information.

- The annual deductible does not apply to wellness services, including well baby care, routine check-ups, routine immunizations, plus routine screenings, labs and x-rays.
- Abnormalities or problems identified by all routine screening procedures may result in additional copayment or coinsurance being applied.
- Calendar year limits are reached by accumulating the paid amounts for all applicable services received.
- For maternity service under all plans shown, if a provider submits one bill for delivery and pre- and postnatal care office visits, the claim will be paid at the same benefit level as in-hospital physician services. If the provider bills for these services separately, outpatient benefits will apply to outpatient services. Network physicians have agreed to submit one bill.

Anthem BlueCare Plans

These charts provide a summary and partial description of plan benefits per person. Please refer to enrollment materials for detailed information and related provisions. For a comparison of other plans available, visit our Web site at www.anthem.com

		Plans	Anthem BlueCare Copayment Plans				
			15	20	25	30	30/2000
THE BASICS	Annual Deductible <small>Family Deductible = 2x per person amount</small>		None	None	\$500	\$1,000	\$2,000
	Copayment	Doctor Visits				Deductible does not apply to wellness services	
		PCP	\$15	\$20			
		Specialist	\$30	\$40	\$25	\$30	\$30
	Coinsurance		20%	20%	20%	20%	20%
	Annual Out-of-Pocket Expense Limit <small>Family Expense Limit = 2x per person amount</small>		\$2,000	\$3,000	\$2,500	\$3,000	\$4,000

THE BENEFITS	Well Baby Care until 7 th birthday	Office Visits	PCP: \$15 Spec: \$30	PCP: \$20 Spec: \$40	\$25	\$30	\$30
		Screening Tests	20%	20%	20%	20%	20%
		Immunizations	No Copay	No Copay	20%	20%	20%
	Labs, X-rays & Most Screenings <small>such as annual mammograms for ages 35 and older</small>		20%	20%	20%	20%	20%
	Vision Care	Blue View Vision Network	\$15 for annual routine eye exam. No deductible applies.				
	Out-of-Network	\$30 allowance (member pays the rest of what the eye professional charges)					
	Emergency Room or Outpatient Facility Charges	In-Network					
		Facility Copay	\$100	\$100	No Copay	No Copay	No Copay
		Coinsurance	20%	20%	20%	20%	20%
		Physician Services	PCP: \$15, Spec: \$30	PCP: \$20, Spec: \$40	20%	20%	20%
	Hospital Inpatient Care and Services	In-Network					
		Facility Copay	\$300	\$400	No Copay	No Copay	No Copay
		Coinsurance	20%	20%	20%	20%	20%
		Physician Services	20%	20%	20%	20%	20%

Anthem BlueCare Plans

These charts provide a summary and partial description of plan benefits per person. Please refer to enrollment materials for detailed information and related provisions. For a comparison of other plans available, visit our Web site at www.anthem.com

		Plans	Anthem BlueCare Deductible Plans			
			200	500	1000	2000
THE BASICS	Annual Deductible <small>Family Deductible = 2x per person amount</small>		\$200	\$500	\$1,000	\$2,000
	Copayment		None	None	None	None
	Coinsurance		Unless otherwise stated, members pay the coinsurance shown for covered services after paying the applicable deductible. Deductible plans do not include copayments			
	Annual Out-of-Pocket Expense Limit <small>Family Expense Limit = 2x per person amount</small>		\$1,500	\$2,500	\$3,500	\$4,000

		Plans	Anthem BlueCare Deductible Plans			
			200	500	1000	2000
THE BENEFITS	Well Baby Care <small>until 7th birthday</small>	Office Visits	20%	20%	20%	20%
		Screening Tests	20%	20%	20%	20%
		Immunizations	20%	20%	20%	20%
	Labs, X-rays & Most Screenings <small>such as annual mammograms for ages 35 and older</small>		20%	20%	20%	20%
	Vision Care	Blue View Vision Network		\$15 for annual routine eye exam. No deductible applies.		
Out-of-Network			\$30 allowance (member pays the rest of what the eye professional charges)			
Emergency Room or Outpatient Facility Charges		20%	20%	20%	20%	
Hospital Inpatient Care and Services		20%	20%	20%	20%	

Prescription Drugs

For greater cost savings, prescription drugs are categorized into three tiers under our plans.

- Tier 1:** Drugs with the lowest copayment. These are usually generic drugs. Generics contain the same active ingredients as brand drugs. They simply cost less.
- Tier 2:** A moderate copayment applies. These are usually brand-name medications that are safe and effective for most people and offer a better value than some other brand-name drugs on the market.
- Tier 3:** These are the drugs that are going to cost you the most. These are often brand-name drugs that are higher in cost than therapeutically equivalent drugs on lower tiers. Sometimes these are drugs that don't have a therapeutic equivalent, but are determined to be third tier solely based on cost.

Members can purchase up to a 31-day supply of prescription drugs through any participating retail pharmacy as follows:

Prescription Drug Options			
			with \$150 deductible
Tier 1	\$10	\$10	\$10
Tier 2	\$20	\$30	\$30
Tier 3	\$35 or 20% whichever is greater; \$200 out-of-pocket max per script	\$50 or 20% whichever is greater; \$200 out-of-pocket max per script	\$50 or 20% whichever is greater; \$200 out-of-pocket max per script

Plans with a \$150 per member drug deductible include a family deductible for prescription drugs, which is equal to 2x the per member amount, or \$300. Also, the drug deductible applies only to Tier 2 and Tier 3 drugs.

For prescription drug plans that include a \$150 drug deductible, amounts applied to that drug deductible during the 4th quarter (October, November and December) carry over to the following year's calendar year deductible.

The prescription drug benefit has an annual \$3,500 out-of-pocket expense limit per person to protect our members.

Cost Savings for 90-day Supply

If members use maintenance medications, they save money by ordering up to a 90-day supply through WellPoint NextRx®, our mail order pharmacy program, and it's like paying for two months and getting a one-month supply of their prescription drugs free! Here's how it works:

If a member orders through WellPoint NextRx, the cost of up to a 90-day supply is:

2x the 31-day amount per tier (Example: If the plan's Tier 1 member payment is \$10, then a 90-day supply of a Tier 1 drug through WellPoint NextRx costs 2 x \$10 = \$20.)

For Tier 3 drugs, mail service benefits are 2x the copay amount or 20% with a \$400 out-of-pocket maximum per script.

Contraceptives

Coverage for prescribed birth control pills, contraceptive devices, implants, and injectables is available through an optional coverage rider. Details available on request.

Diabetic Supplies

Most diabetic supplies (including glucometers) that can be obtained through a pharmacy are covered under the prescription drug benefit. Insulin pumps are covered under the durable medical equipment provision, since they cannot be obtained at a pharmacy.

Generic drugs

Generic drugs will always be dispensed when available. If the doctor or member requests a brand name drug when a generic is available, the member will pay the difference in cost, plus any applicable copayments. Prescription drugs may be obtained through a participating network pharmacy. Some medications may require prior authorization and/or have quantity limits.

Anthem receives financial credits from drug manufacturers based on total volume of claims processed for their products used by Anthem members. Anthem retains these credits as part of its fee to administer the program for self-funded groups and help stabilize rates for fully-insured groups. These credits do not affect reimbursements to pharmacies.

Specialty Pharmacy Network

Certain specialty drugs are available only through WellPoint Specialty network and require prior authorization to obtain. Specialty drugs are high cost, biotech drugs, usually injected or infused and used to treat acute or chronic disease. These drugs often require special handling and are typically unavailable at retail pharmacies.

Enrolling in an Anthem Plan

Eligibility

For your group to become eligible for Anthem coverage, your company will need to meet certain minimum participation and contribution guidelines. Once these conditions are met, your employees who meet member eligibility guidelines can enroll themselves and their family members. These can include dependent children, who are covered until the end of the calendar year in which they turn 23 if enrolled before their 23rd birthday, or until the last day of the month in which they marry (whichever occurs first).

For more specific information on group or employee eligibility, ask your agent or call your Anthem Sales Representative at 1-800-543-8919 or 804-354-2625 from Richmond.

Coordination with Other Coverage

Anthem will coordinate benefits for enrolled members who have additional health care coverage with other carriers. After initial information or updated information is provided, we'll take care of the paperwork for you and your employees, a service that provides you with additional cost controls and your employees with the convenience of little or no paperwork.

If you have any questions about how we coordinate benefits, please contact your Anthem Representative.

Pre-Existing Conditions and Waiting Period Waivers

A pre-existing condition is a medical condition, other than pregnancy, for which advice, diagnosis, care, or treatment was recommended and/or received during the 6-month period prior to the enrolled member's enrollment date in your company's plan. If an employee or a covered family member was diagnosed with breast cancer, but has not had a recurrence within the past five years, the breast cancer is not considered a pre-existing condition. During the first 12 months of enrollment, services for these pre-existing conditions are not covered. Exceptions are infants who have been covered under an Anthem health plan or other creditable coverage within 31 days of birth, or an adopted child or a child placed in the home for adoption before reaching the age of 18, if enrolled within 31 days of initial eligibility or covered by creditable coverage within 31 days of the adoption or placement, and if there has not been a significant break in coverage (63 or more days) before enrollment.

When groups of 10 to 50 become newly enrolled, Anthem may waive the waiting period for members' pre-existing conditions for those who were enrolled under the group's previous health care plan.

When an individual employee, such as a newly hired employee, joins your group, Anthem will deduct from the 12-month waiting period for pre-existing conditions the number of months the employee was enrolled in:

- Most types of group or individual health insurance programs or HMO plans;
- Most types of health service plans or fraternal society plans;

- A Medicare, Medicaid, TRICARE or similar publicly-sponsored program.

The employee will receive credit for previous coverage as long as there was no more than a 63-day break in the employee's coverage prior to the date of enrollment with Anthem. To obtain credit toward the pre-existing condition/exclusion period, the employee will need to provide a certificate of coverage from the previous program or employer that issued the previous coverage. The employee's previous benefits administrator may be helpful in providing this certificate. Employees can call Member Services if they would like our help in obtaining a certificate of prior coverage.

Elements of Premium

Your group's premiums are based in part on the location of the employer, the age and dependent status of each enrolled employee, the number of enrolled employees, the health status of enrolled employees and their dependents, and the benefit plan selected.

Renewability and Cancellation of Coverage

Anthem will renew coverage for your group at the group's option as long as group eligibility guidelines, including the following, are met:

- Maintain a bona fide employer-employee relationship with all covered persons;
- Meet Anthem's minimum participation and contribution guidelines;
- Pay the appropriate premium when due;
- Be located within Anthem's service area; and
- Do not commit fraud or misrepresentation.

If premium payments fall into delinquency after a grace period of 31 days, the Group Policy may be terminated. Coverage will remain in effect during this grace period. If payment is not made within the grace period, the employee may be held liable for the cost of any service received after this period.

In certain situations, Anthem may terminate the Group Policy:

- If Anthem discontinues offering a particular type of coverage that your Group Policy reflects, Anthem will give at least 90 days written notice to you and your group.
- If Anthem discontinues offering all health insurance coverage in the Commonwealth of Virginia, Anthem will give at least 180 days written notice to your group and the Virginia State Corporation Commission.

The policyholder may cancel the Group Policy on the last day of the month by giving written notice to Anthem at least 30 days in advance.

Cancellation of an Employee's Coverage

Anthem Blue Cross and Blue Shield coverage may be terminated for cause immediately for misrepresentation and upon 31 days written notice under conditions such as failure to make any required payment, use of the member's ID card by any other person, or fraud.

Amendment of Group Coverage

Anthem may amend your group's policy by giving written notice to the policyholder at least 30 days in advance. However, the benefit levels or covered services specified in your Group Policy may not be reduced except on any anniversary date of the policy.

Exclusions: Services Not Covered

To help manage the cost of health care premiums for all groups, Anthem Blue Cross and Blue Shield excludes from coverage certain services. More information is provided in individual policies, but here is a detailed list of exclusions to help you evaluate the extent of our coverage. The following services will not, under any circumstances, be covered by Anthem Blue Cross and Blue Shield. Unless another type of service is specified, the word "services" means both services and supplies. Benefits for the following will not be provided:

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. Benefits for, or related to, **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 Your coverage does not include benefits for the following **dental services**: treatment of natural teeth due to diseases; treatment of natural teeth due to accidental injury occurring on or after your *effective date* of coverage, unless treatment was sought within 60 days after the injury and *you* submitted a treatment plan to *Anthem* for prior approval; 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 Family planning services, including: 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 (except for Diabetic 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 Benefits for **hearing care** except as described in the brochures and enrollment materials. Benefits for implantable or removable hearing aids, with the exception of Cochlear implants. • 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 unmarried children. • **Medical equipment (durable)**, 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 lost or damaged 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 the member from appealing Anthem's 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 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. 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 outpatient hospital setting, emergency room, or 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 Services and supplies related to **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. • **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: 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; birth control medications or devices; 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, custodial, 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. Coverage does not include benefits for care from a **residential treatment center** or other non-skilled sub-acute settings, except to the extent such setting qualifies as a substance abuse treatment facility licensed to provide a continuous, structured, 24-hour-a-day program of drug or alcohol treatment and rehabilitation include 24-hour-a-day nursing care

S Services or supplies if they are: ordered by a doctor whose services are not covered under the 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 the 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 a member waives his or her 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 a member would not have been charged if he or she 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, coverage does not include benefits for services for **sex transformation**. This includes medical and mental health services. The following **skilled nursing** facility stays including: treatment of psychiatric conditions and senile deterioration; facility services during a temporary leave of absence from the facility; or a private room unless it is medically necessary. • 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; or recreation therapy. This includes, but is not limited to, sleep, dance, arts, crafts, aquatic, gambling, and nature therapy.

V **Vision services** or supplies unless needed due to eye surgery and accidental injury; routine vision care and materials except as described in the brochures and enrollment materials; services for

radial keratotomy and other surgical procedures to correct refractive defects such as nearsightedness, farsightedness and/or astigmatism. This type of surgery includes keratoplasty and Lasik procedure; services for vision training and orthoptics; tests associated with the fitting of contact lenses unless the contact lenses are needed due to eye surgery or to treat accidental injury; sunglasses or safety glasses and accompanying frames of any type; any non-prescription lenses, eyeglasses or contacts, or Plano lenses or lenses that have no refractive power; any lost or broken lenses or frames; any blended lenses (no line), oversize lenses, progressive multifocal lenses, photochromatic lenses, tinted lenses, coated lenses, cosmetic lenses or processes, or UV-protected lenses; services needed for employment or given by a medical department, clinic, or similar service provided or maintained by the employer or any government entity; 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 the member waives his or her right to payment under these laws and regulations or fails to comply with the 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.

Policy Limitations for Anthem BlueCare Plans

All policies cover certain services up to a preset limit. For example, visits with a health care provider may be limited by the number of visits, or services may be limited by a maximum dollar amount. Once a member reaches the preset limit on a service, the policy will not pay benefits for that service for the rest of the calendar year. (A calendar year runs from January 1 to December 31.)

Benefits with Yearly Limits

• Durable medical equipment	\$5000
• Early Intervention Services (combined maximum; up to age 3)	\$5000
• Manual medical intervention (includes spinal manipulation)	\$500
• Outpatient private duty nursing	\$500
• Ground ambulance services	\$3000
• Physical and occupational therapy (combined maximum)	\$2000
• Speech therapy	\$500
• Skilled nursing care	100 days per confinement
• Home health care services	90 visits (applies only to BlueCare 15 and BlueCare 20)

Limitations for Out-of-Pocket Expenses

The following do not count toward a member's out-of-pocket expense limits for covered services:

- Amounts above the allowable charge
- Amounts above health plan limits
- Expenses for prescription drugs under the prescription drug benefit
- Expenses for routine vision care
- Expenses for supplies or services not covered by the health plan
- Expenses for dental services provided by separate contract, certificate, or amendment to the health plan

This brochure is not a contract or policy. It is a summary and partial description of benefits available through Anthem's BlueCare plans. If there are any differences between this information and the Group Policies, the provisions in the Group Policy will govern. Benefits, exclusions and restrictions can be found in the following Group Policies and endorsements.

Anthem BlueCare Products:

GP-1 (07/02) et. al GP-1-TOC, GP-1-ELIG (01/08), GP-1-GEN (08/07), PP-INTRO (08/07), P-TOC (07/07), P-SB1 (07/07), P-SB2 (07/07), P-SB3 (07/07), P-SB4 (07/07), P-COVERED (07/07), P-EXCL (07/07) P-CLAIMS (10/07), P-COB (08/07), P-ENR (07/07), P-ENDS (07/07), P-INFO (10/07), P-RIGHTS (01/05), P-DEF (07/07), P-EXH-A (07/04) P-ACC (03/00), P-INDEX (02/05), V-INTRO (07/07), V-TOC (07/03), V-WORKS (07/06), V-COVERED (07/06), V-EXCL (07/06), V-CLAIMS (07/06), V-ENR, V-INFO (07/06), V-DEF (07/06), and V-INDEX (07/03).



Anthem'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's provider networks include a number of physicians, medical facilities and health care professionals located in those areas and in other contiguous regions outside of the Anthem service area.

Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Virginia, Inc. An independent licensee of the Blue Cross and Blue Shield Association.

® Registered marks Blue Cross and Blue Shield Association.

Express Scripts, Inc. (ESI) is a separate company that provides pharmacy services and pharmacy benefit management services on behalf of health plan members. WellPoint NextRx, NextRx and PrecisionRx are registered trademarks of WellPoint, Inc. and are used under license agreement by ESI.