

FOR INDIVIDUALS AND FAMILIES



Lumenos[®] Health Savings Account (HSA) Standard Plan

**A Consumer-Driven Health Plan
Available Regardless of Your Health
Status or Medical History**

- Access to Anthem's Preferred Provider Network of Doctors and Hospitals
- Compatible with a Health Savings Account

More control over your health care dollars.

Immediate preventive care.

Access to our PPO provider network.

Sound like a plan?

**As a matter of fact, it sounds just like our Lumenos®
Health Savings Account (HSA) Standard Plan.**

What's different about the Lumenos Health Savings Account Standard? Everything! You get:

- Immediate, 100% coverage for preventive care (before meeting your deductible) to support and encourage your healthy lifestyle when using in-network providers. You may pay more for using out-of-network providers.
- Choice of deductibles (Single: \$1,500/\$3,000/\$5,000 and Family: \$3,000/\$6,000/\$10,000)
- A deductible to pay for medical expenses out-of-pocket after your Health Savings Account has been exhausted and before your traditional medical coverage kicks in
- Access to our PPO network of doctors, hospitals and specialists located in convenient locations all across Virginia
- The option to set up a Health Savings Account (HSA) through Mellon Bank that works hand-in-hand with your health plan (or you can set up an HSA at the financial institution of your choice)
- The opportunity to fund your HSA with pre-tax dollars which are used for your qualified medical expenses (2010 and 2011 HSA contribution limits set by the IRS are \$3,050 for those with self-only coverage and \$6,150 for those with family coverage)
- Optional coverage for Maternity, with the \$3,000 and higher deductible options

With the \$5,000 deductible plan for Single policies or \$10,000 deductible plan for Family policies, you'll receive 100% coverage for in-network services once your deductible is met. And if you choose the lower deductible options, you'll receive 80% coverage (you pay just 20% coinsurance) for in-network services once your deductible is met. Using out-of-network services may cost you more.

- Deductible- The amount you have to pay each calendar year for covered services before your health care plan starts paying.
- Traditional PPO Coverage – Receive benefits and access to quality care from our PPO network providers

Lumenos HSA Standard Benefit Summary

Anthem's Lumenos HSA Standard plan is available to you regardless of your health status or medical history. This means you can't be turned down for this coverage based on your health! With Lumenos HSA Standard, you get basic personal or family coverage.

Before you begin reviewing your benefits, here are a few important terms you should know...

- **Allowable Charge** - The allowance Anthem determines for covered services. Participating providers accept Anthem's allowable charge as payment in full.
- **Coinsurance** - The percentage of the allowable charge you pay for services covered by your policy after you meet your deductible.
- **Deductible** - The amount you pay toward covered health care services each calendar year before receiving benefits. Your policy has one deductible which applies to all covered persons. There's no other deductible to meet.
- **PPO Network Providers** - These medical professionals accept Anthem's allowable charge as payment in full. This means that even if you haven't met your deductible, you can still save on the cost of covered services by visiting these providers. With over 15,500 PPO providers and over 80 hospitals, chances are your provider already participates. Just visit a network provider to take advantage of the savings.¹
- **Non-Network Providers** - Non-Network providers may not accept Anthem's allowable charge as payment in full and may bill you for the difference. With a PPO network plan, when you visit a provider who is not in the PPO network, your share of the cost for covered services also increase through higher coinsurance and a separate out-of-pocket expense limit.

Review the chart to the right for available deductible options, and choose the option that best fits your needs.

All services require a deductible, unless otherwise stated.

¹ BCBSA Provider Data Counts 2010

This chart lists benefits that apply for each person on a policy

Lifetime maximum	Unlimited	
TYPE OF COVERAGE & NETWORK	Network	Non-Network
	Anthem PPO Network Providers; No gatekeepers or referrals.	Use any provider; No gatekeepers or referrals.
COVERED SERVICES		
Deductible (combined for in and out of network)	Single \$1,500-20%-\$4,500 \$3,000-20%-\$5,000 \$5,000-0%-\$5,000	Single \$1,500-40%-\$9,000 \$3,000-40%-\$10,000 \$5,000-30%-\$10,000
Coinsurance & Out of Pocket Expense Limit (separate for in and out of network)	Family \$3,000-20%-\$9,000 \$6,000-20%-\$10,000 \$10,000-0%-\$10,000	Family \$3,000-40%-\$18,000 \$6,000-40%-\$20,000 \$10,000-30%-\$20,000
Doctor visits/ outpatient services	0% or 20%	30% or 40%
Prescription drugs	Non-specialty drugs: 0% or 20% Specialty drugs: 0% or 20% when purchased from Anthem's Specialty Pharmacy Network.	Non-specialty and specialty drugs: 30% or 40%
Emergency services	0% or 20%	
Hospital inpatient services	0% or 20%	30% or 40%
Preventive care <small>Covers nationally recommended preventive care for adults and children including immunizations, PSA screenings, Pap tests, mammograms and more.</small>	0%, not subject to deductible	30% or 40%
Dental care	Optional coverage rider available.	
Mental Health & Substance Abuse <small>per person, per calendar year</small>	0% or 20%	30% or 40% 25 day maximum inpatient care. 20 visit outpatient visit limit

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, so you can find coverage that best fits your life today, and tomorrow.

Maternity

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 (see page 8 for the definition of a pre-existing condition). Pregnant women who are HIPAA (Health Insurance Portability and Accountability Act) "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. Maternity benefits are available with deductibles of \$3,000 and higher.

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.

What if I want to add or remove optional coverage later?

Generally, you can add or remove 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

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.

Dental coverage provides preventive, restorative and complex care up to \$1,000 per year for each covered person.

Optional Dental Covered Services

Preventive Care					
COVERED SERVICES	WAITING PERIOD	COINSURANCE		DEDUCTIBLE	
		In-Network	Out-of-Network	In-Network	Out-of-Network
Diagnostic (2 Oral Exams)	None	0%	50%	None	None
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	
		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
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 planning)					

Support for Healthier Lifestyles

In addition, the Lumenos HSA Standard plan surrounds you with the support you need to help manage your health to the fullest. This 360° Health support includes:

- MyHealth Assessment – This confidential online health profile takes only a few minutes to complete. It helps you identify possible health risk factors, based on your current health, family history, lifestyle and other factors. You and your covered family members are eligible to complete the MyHealth Assessment.
- Personal Health Coach – If you have one of over 40 chronic medical conditions, such as asthma, diabetes, cancer or heart disease, you have the opportunity to work with a specially trained nurse to help you manage your condition.
- Healthy Lifestyles: Tobacco-Free Program – This step-by-step program combines proven techniques and personalized support to help you stop using tobacco. It features nine one-on-one telephone counseling sessions to help you develop your own plan of action, including determining what nicotine-replacement products may work best for you. And, while you're participating, the program also includes coverage for nicotine-replacement products (gum or patch). You and your covered family members over 18 are eligible for this program.
- Healthy Lifestyles: Healthy Weight Program – If you and/or your covered family members age 18 or older have a Body Mass Index (BMI) of 25 or higher, check out this program. It includes nine one-on-one telephone counseling sessions designed to help you achieve a weight that supports good health. Working with a registered dietician and health educator, you'll have confidential phone sessions to discuss topics like healthy eating, exercise, stress management, and weight maintenance.

As you can see, the Lumenos HSA Standard plan gives you comprehensive PPO coverage and a whole lot more. If the Lumenos HSA Standard sounds like the plan for you, give your Anthem sales representative a call. We'll be glad to answer your questions and help you enroll.

Dollars and Sense: Your HSA with Mellon Bank

Your Health Savings Account works hand-in-hand with your Lumenos HSA Standard health plan. Anthem makes it easy to get your account started. We've partnered with ACS/Mellon Trust of New England® (Mellon) to make establishing and managing your HSA simple - we'll even set up the account for you once you're approved for our health plan coverage. Or, if you would rather use another financial institution, that's fine too.

Take advantage of the opportunity to make tax-deductible contributions to your HSA, and then use it to help pay for your qualified medical expenses, including prescription drugs. You'll also have the convenience of calling just one customer service number - and visiting one handy website - for both your health plan and your HSA. And, of course, Mellon offers you competitive interest rates as well as investment options for your HSA funds. To get the most out of your Health Savings Account, be sure to talk with your tax advisor.

After you enroll in this health plan and the Mellon Health Savings Account, you'll soon receive your HSA Welcome Kit which will provide more details, directions and documents. If you have questions, feel free to call your Anthem sales representative.

It's easy to see that the Lumenos HSA Standard - combined with a tax-advantaged Health Savings Account - makes sense for your health care and your health care dollars!

**Considering an
HSA? Talk with
your tax advisor.**

Policy Terms

Listed below are provisions to this policy. These outline specific requirements and procedures about our plan. 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.

You should know about...

Eligibility

Lumenos HSA Standard coverage is available only to those who:

- are Virginia residents and reside in the Anthem Blue Cross and Blue Shield service area*; Reside in the KeyCare service area;
- are not entitled to Medicare benefits;
- do not currently have individual protection that provides similar benefits, unless Lumenos HSA Standard will replace existing coverage; and
- are not on active duty with any branch of the Armed Services.

Eligible children must also be:

- under age 26.
- unmarried, age 26 and older who are incapable of earning a living because of a mental or physical handicap that began before age 26

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

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

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

Renewability

Your coverage is automatically renewed as long as:

- premiums are paid as they come due;
- 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 this coverage.

This policy may not be renewed if all policies under the same form number are also not renewed. Any such action will be in accordance with any applicable state and Federal laws.

Premium

We determine premiums based on such factors as age, sex, type and level of benefits, membership type 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.

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.

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 person begins active duty with the Armed Services;
- death of the dependent; or
- at the insured's request.

In addition, coverage ends for covered dependent children under these circumstances:

- at the end of the month in which a covered child turns 26; or

If a covered child is incapable of earning a living because of a mental or physical handicap that began before age 26, we will continue to cover the unmarried child as long as the policy is in force.

Credit towards waiting periods

For applicants age nineteen (19) and older, this policy has a 12 month pre-existing condition waiting period. No credit is given toward this waiting period for prior time served under any individual or group coverage, including Anthem, unless you are an "Eligible Individual" (HIPAA), as defined on the application.

Employer payment for premiums

The policy described in this brochure is an individual health insurance policy, and, as such, cannot be used as an employer-provided health care benefit plan. No employer of any covered person under this policy 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/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.

Coordination of benefits

Anthem Blue Cross and Blue Shield individual 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.

* If you are an "Eligible Individual", as defined on the application, then coverage is available to those who live, work or reside in our service area.

Utilization Management and Case Management

Our Utilization Management (UM) services offer a structured program that monitors and evaluates member care and services. The UM clinical team, which is made up of health care professionals who hold active professional licenses and certificates, perform the prior authorization, concurrent and retrospective review processes explained below. The UM team follows criteria to assist in decisions regarding requests for health care and other covered benefits, and complies with specific timeframes to ensure requests are handled in a timely manner. Our case management services help you to better understand and manage your health conditions.

Prospective Review / Admission Review

Prospective review (also known as pre-service or admission review) is the process of reviewing a request for a medical procedure or service before it takes place. The review occurs to ensure that: 1) the procedure is medically necessary and 2) the procedure meets your health care plan's specific guidelines prior to being performed. Requests for prospective review may include but are not limited to:

- inpatient hospitalizations
- outpatient procedures
- diagnostic procedures
- therapy services
- durable medical equipment

Prospective review is required for all elective inpatient admissions and certain outpatient services. The review process evaluates medical necessity and the best level of care and assigns expected length of stay if needed.

Concurrent Review

Concurrent review is an ongoing evaluation of a member's hospital stay, as well as ongoing extensions of services that may be needed (such as acute care facilities, skilled nursing facilities, acute rehabilitation facilities, and home health care services). The review includes physicians, member-assigned health care professionals (or member authorized representative) and takes place by telephone, electronically and/or onsite.

Concurrent review uses pre-set decision criteria in order to approve medical care (deemed to be medically necessary) and assign the right level of care for continued medical treatment. Review decisions are based on the medical information obtained at the time of the review. Concurrent review also helps to coordinate care with behavioral health programs.

Retrospective Review

The retrospective review process consists of obtaining information to determine medical necessity as it relates to services provided without approval or notice ahead of time (e.g. without pre-service notification). Relevant clinical information is required for the retrospective review process. Review decisions

are based only on the medical information the doctor or other provider had at the time the member received medical care.

Case Management

Case managers are licensed healthcare professionals who work with you to help you understand your benefits and support your health care needs. The case manager works with you and your doctor to help you better understand and manage your health conditions.

What is 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 & Limitations:

Our Lumenos HSA Standard policy does 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, this plan does not cover prescription drugs prescribed for a pre-existing condition, services for, or complications resulting from, a pre-existing condition.

This exclusion does not apply to children under the age of nineteen (19) or in certain cases of breast cancer follow-up care. If a covered person has been free of breast cancer for five years or more, based on follow-up medical care that shows negative test results, then the follow-up care they received in the 12 months prior to their effective date will not be considered when determining pre-existing conditions.

Preventive care services

- The policy only covers preventive care specified 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 Investigational

- Services that we deem, in our sole discretion, to be experimental/investigative, as well as services related to or complications from such procedures, except in certain limited circumstances as listed in the policy.

The Blue Cross and Blue Shield Association has a committee of medical professionals that reviews new medical treatments, examines the current scientific medical literature and recommends coverage for those treatments that are shown to be safe and effective. They do not recommend new treatments that are still experimental or under investigation. Our medical staff follows the committee's recommendations and guidelines to decide whether a new treatment can be covered by the policy.

Organ and Tissue Transplants, Transfusions

- Certain organ or tissue transplants that are considered experimental/investigative or not medically necessary.

Maternity and fertility services

- Pregnancy related services except complications of pregnancy related to a pregnancy beginning after the policy effective date; services for artificial or surgical means of conception. Complications of pregnancy include conditions that would be considered life-threatening to the mother and conditions where the diagnosis is distinct from the pregnancy and are caused by or adversely affected by the pregnancy. No other pregnancy or fertility-related services are covered, including fertility services, artificial or surgical conception services, (including prescription drugs prescribed in conjunction with artificial or surgical conception services), prenatal care, labor and delivery services, routine nursing care, or routine circumcision.

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 the 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, farsightedness, and/or astigmatism.

Foot care

- Services for palliative or cosmetic foot care.

Cosmetic services

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

Certain types of therapies

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

Certain facility and home care

- Services for rest cures, residential care or custodial care. Your coverage does not include benefits for care from a residential treatment center or non-skilled, subacute settings, except to the extent such settings qualify as substance abuse treatment facility licensed to provide a continuous, structured, 24 hour-a-day program of drug or alcohol treatment and rehabilitation including 24 hour-a-day nursing care.

Transportation services

- Travel or transportation, except by professional ambulance services as described in the policy.

Services covered under government programs or employee benefits

- Services covered under Federal or state programs (except Medicaid); services for injuries or sickness resulting from activities for wage or profit when 1) your employer makes payment to you because of your condition; 2) your employer is required by law to provide benefits to you; or 3) you could have received benefits for your condition if you had complied with the relevant law.

Services related to the military, war or civil disobedience

- Services for injuries or sickness sustained while serving in any branch of the armed forces or resulting from acts of war.
- Services for injuries or sickness resulting from participation in a felony, riot or any other act of civil disobedience.

Services provided by family or co-workers

- Services performed by your immediate family or by you; services rendered by a provider to a co-worker for which no charge is normally made in the absence of insurance.

Separate charges

- Separate charges for services by health care professionals employed by a covered facility which makes those services available.

Prescription drugs

This policy does not cover:

- prescription drugs prescribed for pre-existing conditions during the first 12 months of coverage for members nineteen and older;
- over-the-counter drugs;
- charges to administer prescription drugs or insulin, except as stated in the policy;
- prescription refills that exceed the number of refills specified by the provider;
- a prescription that is dispensed more than one year after the order of a physician;
- drugs that are consumed or administered at the place where they are dispensed, except as stated in the policy;
- prescription drugs prescribed for weight loss or as stop-smoking aids;
- prescription drugs prescribed primarily for cosmetic purposes;
- prescription drugs dispensed by anyone other than a pharmacy with the exception of a physician dispensing a one-time dosage of an oral medication either at the physician's office or in a covered outpatient setting in order to treat an acute situation; and
- prescription drugs not approved by the FDA.

Other non-covered services

- Services for which a charge is not normally made.
- Amounts above the allowable charge for a service.

- Services or supplies not prescribed, performed or directed by a provider licensed to do so.
- Services if they are for dates of service before the effective date or after a covered person's coverage ends.
- Telephone consultations, charges for not keeping appointments, or charges for completing forms or copying medical records.
- Services not specifically listed or described in this policy as covered services.
- Services to treat sexual dysfunction, including services for or related to sex transformation, when the dysfunction is not related to organic disease. This includes related medical services and mental health services.
- Complications of non-covered services – these services would include treatment of all medical, mental health and surgical services related to the complication.
- Services or supplies ordered by a physician whose services are not covered under the policy.
- Self-help, training, and self-help administered services.
- Manual medical interventions for illnesses or injuries other than musculoskeletal illnesses or injuries.
- services rendered prior to the optional coverage effective date, and services rendered on or after the optional coverage effective date that are directly related to services received before the optional coverage effective date;
- services rendered after the date of termination of the dental coverage;
- dental pit/fissure sealants on other than first and second permanent molars;
- diagnostic photographs;
- dietary instruction or other counseling;
- silicate restorations;
- sedative fillings; root canal therapy on other than permanent teeth; pulp capping (direct or indirect);
- separate charges for pulp vitality tests and bases and liners under restorations;
- therapeutic pulpotomy on other than primary teeth;
- guided tissue regeneration, including flap entry or re-entry and closure;
- gingival curettage;
- separate charges for irrigation or re-evaluation following periodontal therapy;
- periodontal splinting and occlusal adjustments for periodontal purposes;
- controlled release of medications to tooth crevicular tissues for periodontal purposes;
- repositioning appliances or restorations necessary to increase vertical dimensions or restore or correct the occlusion;
- services rendered for purposes other than to eliminate oral disease and/or replace covered missing teeth (mouth rehabilitation);
- gold foil restorations;
- inlays;
- temporary dentures or temporary crowns, or duplicate dentures;
- services to replace teeth that were lost or extracted prior to the rider's effective date;
- services to replace non-functioning teeth;
- fixed bridges when done in conjunction with a removable appliance in the same arch;
- precision attachments for dental appliances;
- tissue conditioning;
- prefabricated resin crowns;
- dental implants and associated services in conjunction with implants;
- consultations (including telephone consultations), charges for failure to keep a scheduled visit, charges for completion of a claim form, or charges for providing information in connection with a claim;

Out-of-pocket expense limit exclusions

The following items never count toward your out-of-pocket expense limit:

- amounts exceeding the allowable charge and expenses for services not covered under the policy.

Optional coverage exclusions

Adding optional coverage to your policy changes certain exclusions in your policy related specifically to services for dental care or pregnancy. 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;

- 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

Maternity coverage covers pregnancies that begin at least six months after the rider becomes effective. Maternity and pregnancy-related benefits are only available to the female insured or the female covered spouse/domestic partner who is at least 18 years of age or an emancipated minor. It does not cover maternity services for dependent children or a male spouse. The six month time period may not apply to you if you meet certain eligibility requirements. Maternity coverage is not available with deductible options lower than \$3000. Call your Anthem Sales Representative for more details.

Benefits with Yearly Limits under this Policy are:

Benefit/Limit Per Member, Per Calendar Year

- early intervention services (up to age 3): \$5,000
- manual medical interventions (spinal manipulation): 15 visits
- outpatient physical therapy and/or occupational therapy: 20 visits combined
- outpatient speech therapy: 20 visits
- 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)

- Dispensed at Pharmacy: Up to a 34 day supply, or no more than 150 units per prescription, whichever is less.
- Ordered through : Mail Order Up to a 90 day supply per prescription.

Dental coverage limitations

DIAGNOSTIC

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

RADIOGRAPHIC

- Set of bitewing x-rays (not in same year as full mouth series x-rays): 1 each calendar year
- Full mouth series x-rays for covered persons age 5 and over: 1 every 3 calendar years. 9 or more bitewing or periapical x-rays taken at one time is considered a full mouth x-ray; Up to 4 individual periapical films, but not in the same year as a complete mouth x-ray series, (does not apply when rendered in conjunction with emergency treatment.)

PREVENTIVE

- Dental cleaning, including periodontal cleanings: 2 each calendar year
- Fluoride application for covered persons under age 16: 2 each calendar year
- Space maintainers for covered persons under age 12: 2 each per lifetime
- Sealants for each unrestored permanent first and second molar for covered persons under age 16: 1 each per lifetime. There must be a lapse of at least 2 years from the time sealants are placed and the time a restoration is performed on the same tooth and surface for benefits to apply.

RESTORATIVE

- 1 amalgam or resin restoration (filling) per tooth per surface: 1 per calendar year. White-colored composite resin fillings will only be covered on anterior (front) teeth. If composite resin fillings 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 year
- 1 onlay, crown or bridge per tooth every 5 calendar years
- 1 partial or complete denture every 5 calendar years
- 1 laboratory rebasing or relining of dentures every 5 calendar years
- 1 crown repair per tooth per lifetime
- 1 crown recementation per tooth per lifetime

ORAL SURGERY

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

ADJUNCTIVE

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

Coverage that travels with you

Today Americans are more mobile than ever. That's why our BlueCard PPO program helps you save on the cost of your coverage when you are outside our service area and need medical care. In most cases, you will save money when you visit a local Blue Cross and Blue Shield provider. For more information, visit anthem.com.

Questions?

Call your Anthem Blue Cross and Blue Shield Sales Representative. They'll give you the straight answers you need to make a good decision about your coverage.



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This summary of benefits complies with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

A high-deductible health plan is not a health savings account (HSA). An HSA is a separate arrangement between an individual and a qualified financial institution. To take advantage of tax benefits, an HSA needs to be established. This brochure provides general information only and is not intended to be a substitute for the advice of a qualified tax professional. This refers to policy 901119-CP.1 et al., Schedule of Benefits

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