

# Virginia Standard

**Comprehensive Major Medical Insurance  
Available Regardless of your  
Health Status or Medical History**

# Virginia Standard Benefit Summary

Anthem's Virginia 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 Virginia 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.
- **Copayment** - A flat, fixed fee you may pay for prescriptions.
- **Deductible** - The amount you pay toward covered health care services each calendar year before receiving benefits. Deductibles apply to each covered person. However, with our family deductible, once two or more covered persons meet two times the individual deductible, no other deductible has to be met for the family for the rest of the year. Amounts paid toward your deductible during the last three months of the calendar year will be applied to your deductible for the following year.
- **Participating 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 (over 90% of doctors and hospitals in Virginia are Anthem Participating Providers<sup>1</sup>). Non-participating providers may not accept Anthem's allowable charge as payment in full and may bill you for the difference.

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.**

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

<b>Lifetime maximum</b>	Unlimited		
<b>Providers/Facilities</b>	Freedom to use any doctor or hospital; however, you'll save more on the cost of covered services by visiting a participating provider.		
<b>Yearly deductible</b>	\$750	\$1,500 \$2,500	\$5,000
<b>Coinsurance</b>	20%	20%	0%
<b>Yearly out-of-pocket maximum</b>	\$5,000	\$5,000	\$0
<b>Doctor visits/outpatient services</b>	You pay 20% or 0% coinsurance.		
<b>Prescription drugs</b>	Prescription card: You pay a separate \$200 deductible, then the greater of a \$10 copayment or 40% coinsurance; -		
<b>Emergency services</b>	You pay 20% or 0% coinsurance.		
<b>Hospital inpatient services</b>	You pay 20% or 0% coinsurance.		
<b>Preventive care</b> Covers nationally recommended preventive care for adults and children including immunizations, PSA screenings, Pap tests, mammograms and more.	You pay 0% coinsurance. Not subject to deductible.		
<b>Dental care</b>	Optional coverage rider available.		
<b>Mental Health and Substance abuse</b>	Outpatient: You pay 20% coinsurance for the first 5 visits; 50% coinsurance for visits 6-20; Inpatient: You pay 20% or 0% coinsurance for a maximum of 25 days.		

<sup>1</sup> The Network Report, Anthem Blue Cross and Blue Shield, October 2004.

# Benefits available at an additional cost

## Otherwise known as Riders.

***Not everyone needs or wants coverage to pay for maternity expenses or visits to the dentist. That's why we offer optional benefits called "riders," so you can tailor your coverage to meet your needs.***

### Dental

You go to the dentist either to prevent things from going wrong, or to get something fixed. Our dental rider covers both types of care: preventive care and restorative care.

There's no deductible or coinsurance to pay for these preventive care services:

- oral exams, cleanings, scaling & polishings and bitewing x-rays twice each year; and
- a full mouth x-ray every 3 years.

Children covered by your plan will also be covered for these preventive care services:

- topical fluoride applications twice yearly through the end of the year they turn 16; and
- 2 sealants in a lifetime, which may be applied no more than once in a year, through the end of the year they turn 16.

### When you can add riders:

You can add riders when you enroll in a policy or at your policy renewal month. You can also add riders whenever you experience major life changes. Some examples are: marriage, birth, adoption, death, divorce, legal separation, adding or deleting a dependent or entering military service. Maternity coverage cannot be added to a policy insuring one male without a female spouse or female domestic partner also on the policy, or to applicants under age 18 unless they are female emancipated minors. Please see the back of this brochure for exclusions and limitations to the riders.

For restorative care, you pay a 20% coinsurance after you meet a separate \$50 deductible for an individual or \$100 for family. As always, using non-participating dentists costs you more.

Restorative care services include:

- Covered fillings (amalgam and resin for anterior teeth);
- endodontics, x-rays in conjunction with covered restorative care;
- oral surgery;
- periodontal services, emergency palliative services; and
- bite plates or splints for TMJ syndrome.

Keep in mind that each person on the policy is covered up to a maximum of \$500 per benefit period for both restorative and preventive care (\$250 of which can be used toward endodontics).

### Supplemental Accident Protection

Emergency care is included in this plan, but the unexpected costs of an accident can add up. By using participating providers, Anthem will pay 100% of the allowable charge, up to \$500 for each accident or injury. Most important, you don't have to meet a deductible before you begin receiving this rider's benefits.

### Maternity

Having a baby can be expensive. So if you're hoping to add to your family any time in the future, you may want to think about adding a maternity rider now. This optional rider is available with the \$2,500 and \$5,000 deductible options and helps pay for childbirth, prenatal and postnatal care, use of the hospital delivery room, hospital bed and board for mother and newborn, routine nursery care, routine circumcision of a newborn, cesarean section deliveries, diagnostic x-rays and laboratory charges after you meet your deductible.

**It's important to plan ahead for this coverage because the maternity rider has a separate six-month waiting period.**

A pregnancy that occurs within six months of adding the rider will *not* be covered even if you qualify for credit toward the base policy's waiting period. However, if you meet certain eligibility requirements, you may not have to wait for the benefits. Please see the back cover of this brochure for more information.

### Coverage that travels with you

Today Americans are more mobile than ever. That's why our BlueCard 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](http://anthem.com).

# 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...

### 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.

### Eligibility

Virginia Standard coverage is available only to those who:

- are Virginia residents and reside in the Anthem Blue Cross and Blue Shield service area;\*
- are not eligible for or covered by any group plan;
- are not entitled to Medicare benefits;
- do not currently have individual protection that provides similar benefits, unless Virginia 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 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.

### 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 age 26.

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.

\* 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.

# Exclusions: What is Not Covered

## Exclusions

Virginia Standard 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 age nineteen (19), properly added covered newborns and adopted children, 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.

### Services that are deemed Experimental or Investigational

- Services that we deem, in our sole discretion, to be experimental/investigative, except in certain limited circumstances as listed in your policy.

### Services not medically necessary

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

### Organ and Tissue Transplants, Transfusions

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

### Hearing services

- Inplantable 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.

### 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.

# Exclusions & Limitations

## Dental services

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

## Vision services

- Services for, or related to, procedures performed on the cornea to improve vision, in the absence of trauma or previous therapeutic process, such as radial keratotomy, a surgical procedure to correct myopia.

## Foot care

- Services for palliative or cosmetic foot care.

## 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 covered services chapter;
- 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 covered services chapter;
- 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.

## Cosmetic services

- All medical, surgical, and psychiatric services for or related to cosmetic surgery and/or cosmetic procedures, including any medical, surgical, and psychiatric 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, and educational, vocational, and recreational therapy.

## 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 other non-skilled, sub-acute setting, 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 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 Services 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.

## Separate charges

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

## Other non-covered services

- Services for which a charge is not normally made.
- 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 psychiatric services.
- Complications of non-covered services – these services would include treatment of all medical psychiatric and surgical services related to the complication.
- Manual or mechanical interventions for illnesses or injuries other than musculoskeletal illnesses or injuries and any services over the first 15 visits.
- Self-help, training and self-administered services, including biofeedback and related testing.
- Vaccinations, immunizations, or other injections not used to treat a current illness, except as specifically provided for in the policy.
- Services or supplies ordered by a physician whose services are not covered under the policy.

## Out-of-pocket expense limit exclusions

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

- amounts we apply to your deductible;
- any coinsurance limitations listed on the back cover;
- amounts exceeding the allowable charge;
- expenses for services not covered under this policy; and
- copayments.

## Limitations

This policy covers certain services up to a preset limit. For example, visits to a health care provider may be limited by the number of visits, or services may be limited by a maximum dollar amount. Once you reach the preset limit on a service, the policy will not pay benefits for that service for the rest of the calendar year. Your policy has 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 this Policy are:

Benefit	Limit Per Person Per Calendar Year	Benefit	Limit Per Person Per Calendar Year
· early intervention services (birth through 2 years) . . . . .	\$5,000	· prescription drugs . . . . .	(up to a 34 day supply, or up to and including 150 units, whichever is less per prescription)
· manual and mechanical medical interventions (spinal manipulation) . . . . .	15 visits	· home health care services . . . . .	90 visits
· outpatient physical therapy and/or outpatient occupational therapy . . . . .	20 combined visits	· psychiatric services . . . . .	20 outpatient visits; 25 inpatient days. Up to 10 inpatient days may be exchanged for 15 partial day psychiatric services. (1 inpatient day = 1.5 partial days)
· outpatient speech therapy . . . . .	20 visits		

## 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%.

- coinsurance (which increases to 25%) for services received at non-participating hospitals or non-contracting substance abuse treatment facilities located in Virginia;
- coinsurance for manual or mechanical medical interventions, including spinal manipulation;
- coinsurance and copayments for prescription drugs and insulin;

- coinsurance for outpatient psychiatric service visits; and
- coinsurance for outpatient physical therapy, outpatient speech therapy, outpatient occupational therapy, durable medical equipment, early intervention services and home health care services.

## Coverage that travels with you

Today Americans are more mobile than ever. That's why our BlueCard 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](http://anthem.com).

## Exclusions to Optional Coverage

As we have stated, all policies and riders have exclusions — things they will not cover. Adding optional coverage, called a “rider” to your policy changes certain exclusions in your policy related specifically to services for dental care, pregnancy or accidents. But other limitations and exclusions continue to apply.

### Dental benefits rider exclusions

The dental rider changes the dental exclusion in your policy to cover all of the services specifically listed in the rider. This rider does not cover:

- services or supplies not listed as covered;
- X-rays for fitting braces;
- space maintainers;
- prosthodontal services, such as dentures, bridges and retainers;
- orthodontic services, including services for braces and other dental appliances;
- general services, such as anesthesia to induce an unconscious state or an intravenous sedative;
- treatment for TMJ dysfunction;
- any service considered unnecessary by general dental standards;
- gold foil restoration (fillings with gold foil material);
- sedative fillings (temporary medicated fillings);
- inlays, onlays and crowns;
- tests and laboratory exams;
- pulp capping (medicating exposed pulp);
- tooth bleaching;
- implants; and
- provisional splinting (bonding loose teeth).

### Dental rider limitations

- Maximum benefit for preventive and restorative services during a benefit period — \$500 per covered person. Of this \$500, up to \$250 is available for endodontics;
- Oral exams — two per benefit period;
- X-rays
  - Bitewing — two per benefit period
  - Full mouth or panorex — once every 36 months;
- Cleaning, scaling & polishing — two per year;

- Fluoride treatments for covered children — topical application twice per benefit period until the end of the year the covered child reaches age 16;
- Sealants for covered children
  - limited to unrestored occlusal surface of permanent posterior teeth;
  - limited to once a benefit period up to two applications per life time;
  - provided until end of year covered child reaches age 16;
- Amalgam restoration — once per surface per benefit period;
- Resin restorations on anterior teeth — once per surface per benefit period.

### Maternity services rider 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. Call your Anthem Sales Representative for more details. Maternity coverage is not available for deductible options of \$750 and \$1,500.

### Supplemental accident rider exclusions

The supplemental accident rider covers ambulance services related to accidents, but it does not cover any of the other capped benefits (benefits with yearly limits) listed in the Limitations section. The rider 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 rider.

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.

This is not your policy and it 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 910002, Schedule of Benefits Form PVA1231 and 01909VAMENABS and Application Form AVA1553 and 01698VAMEN and Rider Form #s AVA1566, 913004.1 and 913006.1. Life and Disability products underwritten by Anthem Life Insurance Company. Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. Anthem Blue Cross and Blue Shield is an independent licensee of the Blue Cross and Blue Shield Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.