

**Your Health.
Your Security.
Your Choice.**

**Choosing the right health care plan
should be as easy as 1, 2, 3.**

1 KeyCare Flexible ChoiceSM

Sensible. Designed to move with you through your life. Offers a choice of additional benefits you can add or remove (for a change in cost), so you don't pay for extra benefits you don't need.

- In-network doctor visits, for routine and sick care, covered before the deductible.
- Prescription drug benefits covered before the deductible.

Essential KeyCare[®]

Affordable. Solid, basic protection that covers the essentials.

- Our lowest premium.
- Three doctor visits per person, for routine or sick care, covered before the deductible.

3 KeyCare Preferred[®]

Comprehensive. Provides strong protection for families.

- In-network doctor visits, for routine and sick care, covered before the deductible.
- Preventive care and immunizations for children included.
- Prescription drug benefits covered before the deductible.

1 KeyCare Flexible ChoiceSM

\$5 Million Lifetime Benefit

After the Deductible, you pay a Coinsurance amount, up to an annual Out-of-Pocket Expense Limit. This Expense Limit helps control your annual out-of-pocket expenses for covered services, including deductible, copayments, and coinsurance.

In Network

Deductible	Coinsurance	Expense Limit
\$500	20%	\$2,500
\$1,500		\$3,500
\$2,500	0%	\$2,500
\$5,000		\$5,000

Family deductible/out-of-pocket expense limit =
2x single deductible/expense limit

Out-of-Network

Deductible	Coinsurance	Expense Limit
\$500	30%	\$5,000
\$1,500		\$7,000
\$2,500		\$5,000
\$5,000		\$10,000

Hospital Inpatient & Outpatient Care

In Network You Pay:	Out-of-Network You Pay:
20% or 0%	30%

Emergency Care

You pay 20% or 0% coinsurance, in or out-of-network¹

Doctor Visits

In Network You Pay

Covered before deductible
\$500 & \$1,500 deductible: \$30 PCP/ \$40 specialist
\$2,500 & \$5,000 deductible: \$20 PCP/\$30 specialist

Out-of-Network You Pay

30%

2 Essential KeyCare^{®1}

\$2 Million Lifetime Benefit

After the Deductible, you pay a Coinsurance amount, with an annual Out-of-Pocket Expense Limit. This Expense Limit helps control your annual out-of-pocket expenses by limiting the amount you pay in Coinsurance.

In Network

Deductible	Coinsurance	Expense Limit
\$500	30%	\$2,500
\$1,500		
\$2,500		

Family deductible/out-of-pocket expense limit =
2x single deductible/expense limit

Out-of-Network

Deductible	Coinsurance	Expense Limit
\$2,500	40%	\$5,000

Hospital Inpatient & Outpatient Care

In Network You Pay:	Out-of-Network You Pay:
30%	40%

Emergency Care

You pay 30% coinsurance, in or out-of-network¹

Doctor Visits

In Network You Pay

First 3 yearly visits: \$30
Covered before deductible

Remaining visits: 30%
Covered after deductible

Out-of-Network You Pay

40%

3 KeyCare Preferred^{®1}

\$5 Million Lifetime Benefit

After the Deductible, you pay a Coinsurance amount, with an annual Out-of-Pocket Expense Limit. This Expense Limit helps control your annual out-of-pocket expenses by limiting the amount you pay in Coinsurance.

In Network

Deductible	Coinsurance	Expense Limit
\$300	20%	\$1,500
\$750		
\$1,500	0%	\$0
\$2,500		
\$5,000		

Family deductible/out-of-pocket expense limit =
2x single deductible/expense limit

Out-of-Network

Deductible	Coinsurance	Expense Limit
\$300	30%	\$3,000
\$750		
\$1,500		
\$2,500		
\$5,000		

Hospital Inpatient & Outpatient Care

In Network You Pay:	Out-of-Network You Pay:
20% or 0%	30%

Emergency Care

You pay 20% or 0% coinsurance, in or out-of-network¹

Doctor Visits

In Network You Pay

Covered before deductible
\$20 PCP/\$30 specialist

Out-of-Network You Pay

30%

¹This applies if covered services are for emergency care as defined by Anthem. Your Anthem Sales Representative has more details.

1 KeyCare Flexible ChoiceSM

\$5 Million Lifetime Benefit

Prescription Drugs

Covered before deductible
 Non-specialty (Tier 1) drugs you pay: \$15 or 40% whichever is greater
 Specialty (Tier 2) drugs: 40% up to \$500 expense limit per prescription; \$10,000 annual expense limit per person

Yearly Benefit Maximum

\$5,000 per person for non-specialty drugs

Routine Wellness Care

In Network You Pay

Doctor Visits for Routine Wellness Care

Covered before deductible
 Copayments depend on deductible chosen.
 Two yearly visits per person.

Screenings

Covered before deductible.
 You pay 20% or 0%, depending on screening. See your brochure for more details. Provides additional \$150 yearly per person for immunizations, labs & X-rays.

Out-of-Network You Pay

30% for doctor visit & screenings
 Two yearly visits per person
 (combined with in-network visits)

Immunizations for Children

Coverage for immunizations only.

In Network You Pay

Covered before deductible
 20%

Out-of-Network You Pay

30%

2 Essential KeyCare[®]

\$2 Million Lifetime Benefit

Prescription Drugs

Separate \$200 yearly deductible per person
 You pay \$15 or 40%, whichever is greater

Coverage for generic drugs only

Yearly Benefit Maximum

\$5,000 per person

Routine Wellness Care

In Network You Pay

Doctor Visits for Routine Wellness Care

One yearly visit per person. If included with first 3 yearly doctor visits, covered before deductible, you pay \$30
 If after first 3 yearly doctor visits, covered after deductible, you pay 30%.

Screenings

Covered after deductible. You pay 30%

Out-of-Network You Pay

40%

(combined with in-network visits)

Immunizations for Children

Coverage for immunizations only.

In Network You Pay

Covered after deductible
 30%

Out-of-Network You Pay

40%

3 KeyCare Preferred[®]

\$5 Million Lifetime Benefit

Prescription Drugs

Covered before deductible
 You pay \$10 or 40%, whichever is greater

Yearly Benefit Maximum

\$5,000 per person

Routine Wellness Care

In Network You Pay

Doctor Visits for Routine Wellness Care

Covered before deductible
 \$20 PCP, \$30 specialist
 Two yearly visits per person

Screenings

Most Covered before deductible. You pay 20% or 0%, depending on screening. See your brochure for more details. Provides additional \$150 yearly per person for immunizations, labs & X-rays.

Out-of-Network You Pay

30% for doctor visit & screenings
 Two yearly visits per person
 (combined with in-network visits)

Preventive Care and Immunizations for Children

In Network You Pay

Covered before deductible
 0%

Out-of-Network You Pay

Same as in-network

We also offer optional benefits at an additional cost. Ask your Anthem Representative for more details.

Some important terms:

Allowable Charge: The allowance Anthem determines for covered services.

Coinurance: The percentage of the allowable charge you pay for covered services, typically after you meet your deductible.

Copayment: A flat-dollar amount you pay for covered services.

Deductible: The amount you pay toward covered health care services each calendar year before receiving certain benefits.

Out-of-Pocket Expense Limit: This is the total amount you are responsible for paying out of your pocket for covered services. It helps control your annual out-of-pocket expenses.

Important Information You Should Know

We're Committed to Your Privacy

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

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

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

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

An Extra Measure of Coordination and Support

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

These programs include:

Admission Review, which is required before all hospital admissions, (except for maternity admissions without complications). Admission Review ensures that you or your fam-

ily members are receiving the most appropriate care, in the most appropriate setting. Anthem must approve a hospital admission in order for you to receive benefits for that stay.

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

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

PRESCRIPTION DRUG BENEFITS

Here are some important facts about our prescription drug benefits:

Prior Authorization

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

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

Generic vs. brand name drugs

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

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

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

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

Coordination of Benefits

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

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

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

Policy Terms

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

Eligibility

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

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

Eligible children must also be:

- unmarried; and
- under age 23

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

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

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

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

Renewability

Your coverage is automatically renewed as long as:

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

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

Premium

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

Employer payment of premiums

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

Termination

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

Covered dependent coverage ends under these circumstances:

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

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

Cancelling your policy

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

Limited Benefit Policy

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

What's Not Covered

EXCLUSIONS:

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

Pre-existing conditions

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

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

Preventive care services

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

Services not medically necessary

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

We cover only medically necessary services in order to keep everyone's premiums down and to make sure services are provided in a safe, approved setting.

What's Not Covered (CONT.)

EXCLUSIONS:

Services that are deemed experimental or investigative

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

Organ and tissue transplants, transfusions

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

Maternity and family planning services

Pregnancy related conditions, except complications of pregnancy specifically provided for in the policy. We only cover complications of a pregnancy that began after your policy started and include conditions that would be considered life-threatening to the mother.

We do not cover family planning services including services and prescription drugs prescribed for or related to artificial insemination or in vitro fertilization or any other types of artificial or surgical means of conception. We also do not cover reversals of sterilization which resulted from a previous elective sterilization.

Dental services

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

Hearing services

Hearing services, except as specifically provided for in the policy. Implantable or removable hearing aids, including exams for prescribing or fitting hearing aids, regardless of the cause of hearing loss, with the exception of cochlear implants.

Vision services

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

Foot care

Services for palliative or cosmetic foot care.

Cosmetic services

All medical, surgical, and mental health services for or related to cosmetic surgery and/or cosmetic procedures, including any medical, surgical, and mental health services to correct complications of a person's cosmetic procedure. Body piercing and cosmetic tattooing are considered cosmetic procedures. "Cosmetic surgery," however, does not mean reconstructive surgery incidental to or following surgery caused

by trauma, infection, or disease of the involved part. We determine, in our sole discretion, whether surgery is cosmetic or is clearly essential to the physical health of the patient.

Certain types of therapies

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

Certain facility and home care

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

Transportation services

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

Services covered under government programs or employee benefits

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

Services related to the military, war or civil disobedience

Services for injuries or sickness sustained while serving in any branch of the armed forces or resulting from acts of war.

Services for injuries or sickness resulting from participation in a felony, riot or any other act of civil disobedience.

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

Services provided by family or co-workers

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

Separate charges

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

Prescription drugs

We do not cover:

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

Other non-covered services

- Services for which a charge is not normally made.
- Amounts above the allowable charge for a service.
- Services or supplies not prescribed, performed or directed by a provider licensed to do so.
- Services if they are for dates of service before the effective date or after a covered person's coverage ends.
- Telephone consultations, charges for not keeping appointments, or charges for completing forms or copying medical records.

What's Not Covered (CONT.)

EXCLUSIONS:

Other non-covered services (cont.)

- 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 administered services.
- Manual medical interventions for illnesses or injuries other than musculoskeletal illnesses or injuries

Out-of-pocket expense limit exclusions

The following items never count toward your out-of-pocket expense limit for KeyCare Preferred and Essential KeyCare:

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

The following items never count toward your out-of-pocket expense limit for KeyCare Flexible Choice:

- amounts paid for prescription drugs, including specialty drugs and insulin;
- amounts exceeding the allowable change, and
- expenses for services not covered under the policy.

Limitations

These policies cover certain services up to a preset limit. Your policy will have detailed information on the benefit limitations that are outlined below.

Benefits with Yearly Limits under these Policies are:

Benefit	Limit Per Calendar Year
• ground ambulance services	\$3,000
• durable medical equipment	\$5,000
• early intervention services (up to age 3)	\$5,000
• manual medical interventions (spinal manipulation)	\$500
• outpatient physical therapy and/or occupational therapy	\$2,000
• outpatient speech therapy	\$500
• home health care services	90 visits

Benefits with Yearly Limits under these Policies are: (cont.)

Benefit	Limit Per Calendar Year
• 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)	\$5,000
• Prescription Drugs	Up to a 34 day supply, or no more than 150 units per prescription, which ever is less.
• Dispensed at Pharmacy	Up to a 90 day supply per prescription.
• Ordered through the Home Delivery Pharmacy Service	

Coinsurance limitations

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

For KeyCare Preferred and Essential KeyCare:

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

For KeyCare Flexible Choice:

- coinsurance and copayments for prescription drugs and insulin.

Important Information

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

Questions?

For more information about Anthem Individual KeyCare Plans, contact your Anthem Sales Representative.



Coverage is not available to Virginians residing in the city of Fairfax, the town of Vienna or the area east of State Route 123.

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