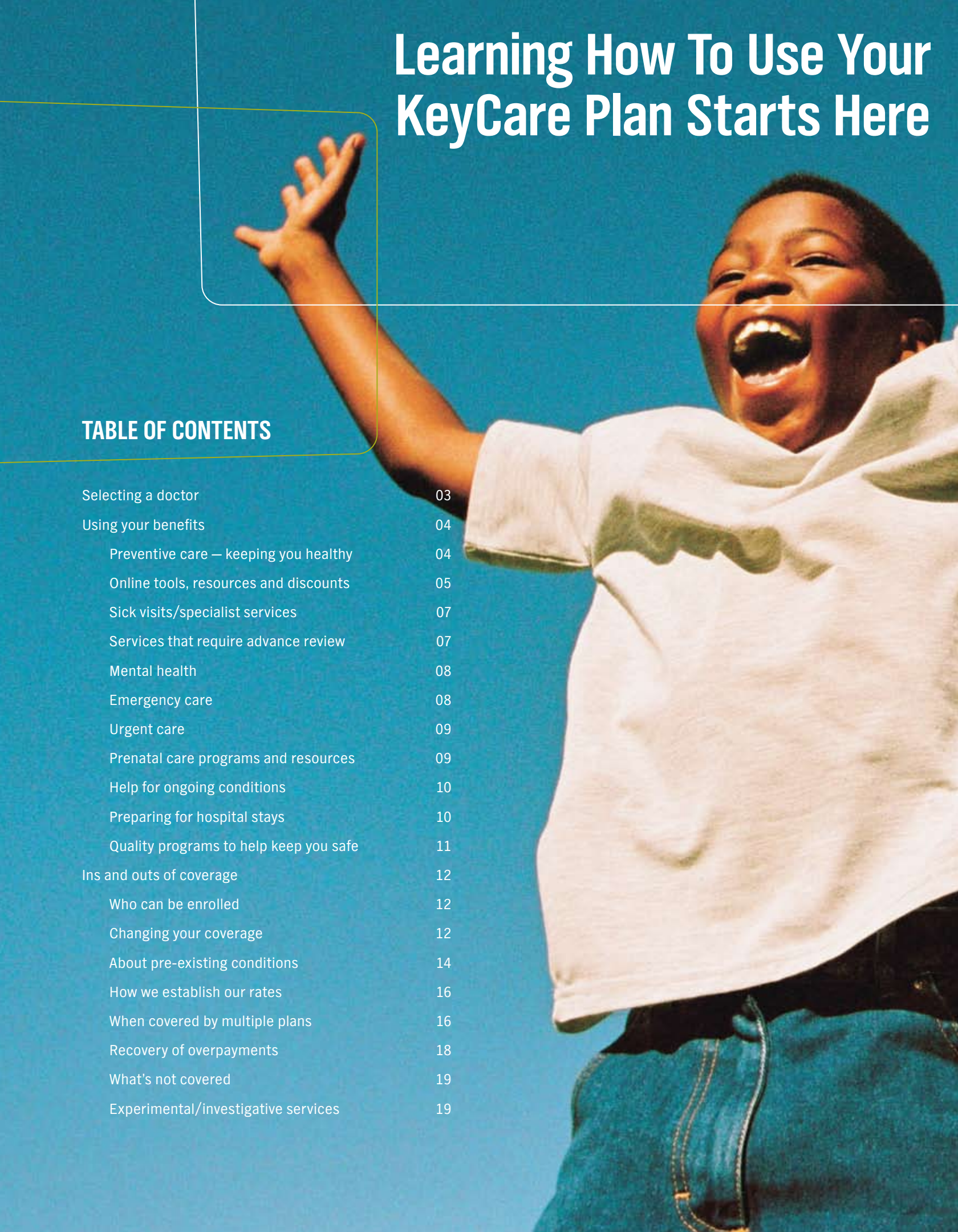
Learning How To Use Your KeyCare Plan Starts Here



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FIRST THINGS FIRST...

360° Health℠

Looking for a health care plan with coverage that's there when you need it? And with access to the doctors you want? Your KeyCare plan will give you that and more. Benefits designed to not only help you stay well, but to help you deal with the unexpected. Plus — you'll get access to important resources that can support you when you have health care decisions to make. And even some extras added in, like discounts. It's all part of an integrated approach called 360° Health®, a set of programs, services and personalized support we have developed to help you improve, manage and maintain your health. Throughout this brochure, you'll learn more about the pieces and parts of 360° Health that work together to help you be at your healthiest.

SELECTING A DOCTOR

As a KeyCare member, you can go to any doctor or hospital you want. But there are advantages to using doctors and hospitals that have an agreement to participate with us (known in the insurance world as being in-network). These doctors and hospitals will:

- file claims for you so there's no paperwork for you to deal with
- work with accepted fees for specific services, so that means less money out of your pocket

And when we say "see anyone you want", we don't just mean the doctors and hospitals in your local area. Your membership also includes BlueCard PPO – a program that links the doctors and hospitals who participate with other Blue Cross and Blue Shield plans throughout the country and in many places throughout the world. This means that just about anywhere you go – or for any special need you have – you'll be able to find a doctor or hospital that is considered "in-network." (Note, the BlueCard PPO program is not available to KeyCare Point of Service members.)

But, what if you want a doctor or hospital not in the network?

No problem. As a KeyCare member, the final choice is yours. Just keep in mind that because these doctors and hospitals don't participate with us, they can charge whatever they want for their services. If what they charge is more than providers in our network have agreed to accept for the same service, you can be billed for the difference.

To access our list of participating doctors, call member services or use the Find A Doctor link on anthem.com. But, we know a list of names doesn't mean very much, especially if there isn't a particular doctor you were searching for. So, you can also narrow the list to only the doctors with the gender and language you're most comfortable with. You'll even be able to see if a particular doctor has received patient satisfaction scores (which we collect annually to learn what our members think about the doctors they've seen).

USING IN-NETWORK PROVIDERS = SAVINGS

You need a checkup. Dr. Smith is an in-network doctor and he's agreed to a fee of $200 for the service. Because he's in-network, you will simply pay whatever amount you would owe under your specific benefits plan, whether it's a specific dollar amount or a percentage of what the doctor charged, like 20% of the $200.

But you visit Dr. Jones instead and he's not in our network. Dr. Jones charges $350 for a checkup. Now you will pay not only the set fee or percentage amount required under your particular benefits plan. You may also pay an additional $150 – the difference in cost between what the in-network doctor agreed to accept as a set fee compared to what the out-of-network provider charged.

Same service – totally different amount that comes out of your wallet. **See why it makes sense to shop around?**

Note: The estimated costs are for illustrative purposes only.

OUR FOCUS IS KEEPING YOU HEALTHY

HOW PREVENTIVE CARE COVERAGE WORKS

Your KeyCare plan has been designed so you receive coverage for checkups and other preventive care benefits as soon as your membership begins, even if you have a plan with a deductible requirement. The amount you'll pay for these covered services will vary based on the type and setting at which they're provided.

There may be times when a preventive care screening reveals something that needs to be treated right away, or at least needs further diagnostic tests. When this occurs, if your provider bills the service as diagnostic, your payment responsibility may change.

For more information on how both diagnostic and preventive care benefits are covered, check the benefits summary that is tucked into this pocket folder.

DOES AN APPLE A DAY KEEP THE DOCTOR AWAY?

Well, it's true that nutritious eating, along with physical activity, can go a long way toward good health. But preventive care is extremely important so conditions are identified before they become serious. If you're a parent, you probably make sure your kids see their pediatrician for all of the age-appropriate screenings and shots. But, when's the last time you had a checkup? We want the whole family to be healthy. So coverage for preventive care is automatically included in all our plans.

PREVENTIVE CARE FOR THE WHOLE FAMILY

From birth through age six, your children will be covered for routine well-baby checkups and screenings:

birth, 3-5 days, 2-4 weeks, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months, 30 months and 3-6 years.[1]

For children over 7 and adults, our preventive care coverage includes[2]:

- checkups
- colorectal cancer screenings
- gynecological exams
- immunizations, certain labs and x-rays done in connection with checkups
- mammograms
- PSA tests and prostate exams
- vision and hearing screenings

1 These well-baby check-up intervals take into account recommendations from the American Academy of Pediatrics and Virginia's Commissioner of Health.

2 This coverage takes into account recommendations by the American Academy of Pediatrics, American Cancer Society, the Advisory Committee on Immunization Practices, and the American Medical Association.

ONLINE TOOLS, RESOURCES AND DISCOUNT PROGRAMS

Health Channels

Check out Health Channels, a feature of MyHealth@Anthem on anthem.com, for tips on healthier eating and physical activities for children of all ages. Health Channels can also steer you to alternative health options and health condition centers for women and men, with topics ranging from important preventive care screenings for adults to dealing with stress and tips for better fitness routines. Plus, you'll find a library of more than 30,000 articles on self-care, medications, conditions, tests and treatments. MyHealth@Anthem is powered by WebMD and includes access to health content and tools not available to the general public.

Preventive Care Guidelines*

When it comes to knowing what screenings your family members need and when, let anthem.com be your guide. By using the Google search feature that is embedded within our site, you can type in "preventive care guidelines" and then download or print preventive care timelines for both children and adults.

Newsletters

Take advantage of the weekly e-newsletters available through Health Channels that are tailored to the topics most important to you.

Health Risk Assessment

Are you as healthy as you feel? Take the online Health Assessment. It's an easy to use tool that can help you learn whether you may be at risk for developing certain conditions later on.

Discounts

Everyone loves a good deal and, as a member, you have your pick of discount offerings available through SpecialOffers@Anthem. Go online and you'll see special rates on items like:

- selected books and magazines
- eyeglasses, contacts lenses, and LASIK
- fitness clubs and weight-loss programs and products
- hearing aids
- home safety products

*These guidelines take into account recommendations from both the American Academies of Pediatrics and Family Physicians.

NEWS THAT'S FIT TO PRINT

The content on Anthem.com is robust enough to handle just about any health question you may have. But, for those who could use a little nudge on what screenings to get and when, or want reminders about tools and resources exclusively available to Anthem members, we also produce Healthy Solutions, Anthem's member newsletter, that is mailed or e-mailed right to your home. Filled with up-to-the minute news on health topics you need to know about and tips for how to get the most out of your coverage.

Smoking Cessation Program

If you're a smoker, you know how hard it can be to quit. When you're ready, we'll be there to help with discounts on smoking cessation products like patches and gum through SpecialOffers@Anthem. You can also visit MyHealth@Anthem to use web-based training tools and access support from trained professionals.

Healthier Eating — Starting With Lunch

With all of the food choices available, combined with a busy schedule, it's no wonder that lunchtime can become a target for nutrition disaster. Over time, poor food choices at lunch can lead to late afternoon snacks, less-than-ideal dinners and an overall unhealthy lifestyle. Making the decision to eat healthier on a regular basis may seem impossible, but we think you can get a good running start by resolving to eat at least one healthier meal a day – starting with lunch. Whether you eat out, pack a lunch from home or eat straight from the vending machine, our Lunch Well program can give you realistic easy-to-use ideas for planning a lunch menu that is not only satisfying, but also healthy. Check it out on anthem.com/lunchwell.

These discount offerings and web site tools are available to you as perks to your membership. Because they are not contract benefits, they can change or be discontinued.

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MORE HELP FOR STAYING HEALTHY AND KEEPING EXPENSES DOWN

- MyHealth@Anthem, powered by WebMD
- Health Channels on anthem.com with information and tools for the whole family
- Online preventive care guidelines
- E-mailed newsletter featuring information on topics you've selected
- Anthem member newsletter delivered or e-mailed to your home
- Health assessment
- Discounts
- Smoking cessation program
- Lunch Well healthy eating program

SICK VISITS/SPECIALIST SERVICES

Scratchy throat. Upset stomach. An ache that won't go away. These are all just a few of the reasons you'll come to rely on the doctor you selected. When you aren't feeling good or are injured – even if you think it's minor — you can count on your KeyCare coverage. Some of the many services covered by your plan include:

- office visits
- emergency care
- lab and X-rays
- home health care
- maternity care throughout your pregnancy
- medical equipment, supplies and appliances
- physical, speech and occupational therapy
- shots and injections
- stays in a hospital or skilled nursing facility
- surgery

TOO BUSY TO SEE A DOCTOR?

With today's fast pace, it can become easy to ignore symptoms or put off seeing your doctor because you have too many other things going on. But, it's important to get those visits in early so you can get a condition or illness treated before it develops into something more serious. As a reminder, you can choose any doctor you want, regardless of specialty, and there are no referrals required. (Note: KeyCare Point-Of-Service (POS) plan members pay less when working with a primary care physician to arrange a referral.*)

WHAT IF THE DOCTOR'S OFFICE IS CLOSED?

Your doctor is the ideal resource for treating any minor health problems but what if the office is closed? MyHealth@Anthem on anthem.com can help, with tools like the interactive WebMD Symptom Checker that lets you identify a symptom — down to the specific ache or pain — and consider the best next step — calling 24/7 NurseLine or going to an urgent or emergency care center.

There is also online help for when you're dealing with more than a minor illness or injury. Through the Treatment Decision Guide, you can learn more about your condition, find options for treatment and specific questions you can print out to take to your doctor's office. But that's not all. You can check out the Treatment Cost estimator so you'll have as much upfront information as possible about what an upcoming medical procedure is likely to cost.

*For more information on your flexibility in working with doctors under POS plans, see the benefits summary tucked into the back of this brochure.

SERVICES THAT REQUIRE ADVANCE REVIEWS

While you can see any doctor or hospital you like, there may be instances in which a test or procedure your doctor wants you to have may not be covered. To help you minimize unanticipated costs from a non-covered service, we work with our in-network providers to make sure that certain services go through an advance review process first. This way, you'll know up front whether the service is going to be covered.

SUPPORT FOR MEMBERS DEALING WITH MENTAL HEALTH OR SUBSTANCE ABUSE ISSUES

If you or a covered family member is struggling with emotional issues or an addiction, you know the toll it takes, not only on the affected person, but the entire family. But you don't have to handle it in silence. Your coverage includes access to our Behavioral Health Unit staffed by a team of trained professionals who are specially licensed to counsel members. They offer confidential help to identify a provider and treatment options, and understand how your benefits work.

AN EXPLANATION OF HOW WE DEFINE EMERGENCY

An emergency is the sudden onset of a medical condition with such severe symptoms that a person with an average knowledge of health and medicine would seek medical care immediately because there may be:

- serious risk to mental or physical health
- danger or significant impairment of body functions
- significant harm to organs in the body (heart, brain, kidneys, liver, lungs, etc.)
- danger to the health of the baby in a pregnant woman

EMERGENCY CARE

Chest pains. A broken arm. There's probably few things more frightening than a medical emergency. By all means, if you ever need emergency medical or behavioral health care, get it. Emergency care is covered no matter where the services are received. If your emergency room visit leads to a hospital stay, be sure to have someone call us within 48 hours.

Sometimes it's hard to decide if your situation is truly an emergency. Using the guidelines to the left will help you make the right choice as well as ensure that the emergency room is available for patients who truly need immediate attention. Keep in mind that if you're having routine ailments like coughs, colds and the flu, your family physician is better equipped and more cost-effective than emergency facilities.

24/7 NURSELINE

Many KeyCare plans provide members with a toll-free 24/7 NurseLine which is comforting if you're not sure whether a sickness or injury requires urgent care. Even if these situations happen in the middle of the night, nurses are standing by to help you determine what to do and can also authorize urgent care services. Ask your group administrator if the 24/7 NurseLine is included in your plan.

URGENT CARE

When a minor illness or injury comes up and your doctor's office is closed, an urgent care center may be a good option. They're covered under your plan benefits and are usually less expensive than ERs, especially when your KeyCare plan requires you to pay a percentage of your visit costs.

PRENATAL CARE PROGRAMS AND RESOURCES

Just found out you're having a baby? Get ready for a rollercoaster of emotions and questions that will go way beyond dealing with pickle and ice cream cravings. You're not having many pregnancy symptoms. Is that ok? Or, you're experiencing constant symptoms. What does that mean? How often is the baby supposed to move and what's with all of the hiccupping he/she is doing? The list of what to think about while you're pregnant can go on and on. Luckily, your KeyCare coverage includes access to a program developed just for expectant parents called Future Moms. With Future Moms, you'll have access to 24-hour telephone support from OB/GYN registered nurses who are reinforced by on-site medical directors, health educators, pharmacists and dieticians. All of these trained professionals are at your disposal day and night to work in collaboration with your doctor's recommendations about how you can prepare for the healthiest pregnancy possible. You'll also receive a book that will tell you what to expect for each week of your pregnancy, guidance for the questions to keep in mind when visiting your doctor and information about dealing with post-partum depression.

Future Moms is available through our affiliate company, Health Management Corporation.

AN EXAMPLE OF SAVINGS

Problem: Your baby has been pulling on her ear and crying and you suspect she has an ear infection, but your doctor's office is closed.

Option A: Visit the emergency room
Charge: $400
Your cost: $80*
* based on an assumption that your plan requires you to pay 20% of what the service costs

Option B: Visit an urgent care center
Charge: $100
Your cost: $20*
* based on an assumption that your plan requires you to pay 20% of what the service costs

Note: The estimated costs are for illustrative purposes only.

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HEALTH EXTRAS, GUIDANCE AND MANAGEMENT THROUGH 360° HEALTH

- WebMD® Symptom Checker
- Treatment Decision Guide
- Treatment Cost estimator
- Advance review of requested tests or procedures
- Behavioral Health dedicated team for mental health or substance abuse issues
- Future Moms prenatal care programs

HELP FOR ONGOING CONDITIONS

Dealing with a chronic condition can really impact your life. Ongoing symptoms. Visits to the doctor or emergency room. Expensive medications and treatments. After a while it can feel like your condition has taken over your life. Our ConditionCare program may be just the solution you've been looking for. ConditionCare is a condition management program for members dealing with asthma, diabetes and certain heart disease conditions. Through ConditionCare you'll be able to talk to specially-trained nurses 24 hours a day for help with any questions you have and get information on treatments that are available. ConditionCare is a resource that you can use, along with your doctor, for support and counsel. This phone access will also enable you to do health assessments right over the phone to determine where you are in terms of controlling your symptoms and whether you're at risk for developing complications.

You can also access the in-depth condition centers on anthem.com. In fact, we not only have centers for these conditions, but for more than 30 others for members dealing with a variety of issues such as allergies, depression and stress.

ConditionCare is available through our affiliate company, Health Management Corporation.

PREPARING FOR HOSPITAL STAYS

Bland food. Unpleasant tests or procedures. And a constant feeling that you just want to go home. Except for having a baby, there's rarely any fun associated with a hospital stay. But knowing all you can before you are admitted can go a long way toward easing your anxiety. One resource that can help is the Hospital Comparison on anthem.com. Through this tool, you'll be able to check hospitals in your area, side by side, for how they compare on quality, based on factors that you select as being most important to you. For example, how often does a particular hospital perform a certain procedure compared with other hospitals in the area? What are the rates for complication? Does the hospital have intensive care staff support?

QUALITY PROGRAMS TO HELP KEEP YOU SAFE

We've also implemented the Quality Hospital Incentive Program (Q-HIP℠) which rewards hospitals for adopting higher level standards of quality for the best patient outcomes. Started as a pilot program in Virginia three years ago, the Q-HIP program is now being offered at hospitals in many other states.

Rest assured that with any hospital stay, you'll have an entire team working on your behalf. The doctors, nurses and discharge planners at the hospital or skilled nursing facility and the KeyCare doctors and nurses on our staff all work together to help make sure you get the right care in the right place at the right time.

Your team is involved in your care from the start and are the ones who discuss the need for you to be admitted to a hospital or skilled nursing facility (called "prior authorization"). With advances in technology, many medical procedures that once could only be done in a hospital can now be done safely in a doctor's office or as an outpatient procedure.

If you do need to be admitted to a hospital or skilled nursing facility, the team will make sure you're getting the right services for your condition, and just as important, make sure you're not going through unnecessary procedures. This phase is called "concurrent review" and tracks the progress you're making while you're still in the hospital or skilled nursing facility.

And when it's time for you to leave the hospital or skilled nursing facility, the team will have also finalized the plan that can help you make a smooth transition back home.

QUALITY PUT TO THE TEST

One Q-HIP measurement that is tracked, for example, is how quickly someone being admitted to the emergency room for a heart attack has a balloon surgically implanted to reduce how hard the heart needs to work. The American Academy of Cardiology sets 90 minutes or less as the optimum for this procedure (called an angioplasty) and research has shown that for every minute past the 90 minute limit, the patient's chance of complications or even death is increased. Our participating Q-HIP hospitals have become significantly better than the national average and have even shown a 52% improvement since the program's inception in 2003.*

*Q-HIP results are based on eight pilot cardiac care hospitals that supplied four years worth of data for the study.

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GUIDANCE AND MANAGEMENT THROUGH 360° HEALTH

- 30+ condition centers
- ConditionCare programs for members dealing with ongoing conditions
- Hospital Comparison tool
- Quality Hospital Incentive Program (Q-HIP)
- Team approach to managing your hospital stays

THE INS AND OUTS OF COVERAGE

Knowing that you have health care that meets you and your family's needs brings peace of mind. But part of your decision in choosing a plan also requires understanding:

- who can be enrolled
- how coverage changes are handled
- what's not covered by your plan
- how your plan works with other coverage

WHO CAN BE ENROLLED

You can choose coverage for you alone or family coverage that includes you and any of the following family members:

- your husband or wife
- your unmarried natural children including children you have adopted or are in the process of adopting
- your unmarried stepchildren or children for whom you are the legal guardian if you provide more than one half of their support as well as children for whom you have court-ordered custody

Under standard plans, dependent children are covered until December 31st of the year they turn 23. If your employer has selected a different age limit, that will be noted on a document that is tucked into the back pocket of this brochure.

Some children have mental or physical challenges that prevent them from living independently. The dependent age limit does not apply to these enrolled children as long as these challenges were present before they reached age 23.

HOW COVERAGE CHANGES ARE HANDLED

Your KeyCare coverage can be renewed, cancelled or changed on two different levels. The first is on the employer level, which would impact you and everyone else covered under your employer's plan. The second level impacts your coverage only — including your covered family members — and does not apply to any others covered under your employer's plan.

1. **On the employer level** — which impacts you as well as all employees under your employer's plan — your KeyCare plan can be …

renewed	cancelled	changed	when…
•			your employer maintains its status as an employer, remains located in our service area, meets our guidelines for employee participation and premium contribution, pays the required health care premiums and does not commit fraud or misrepresent itself.
	•		your employer makes a bad payment, voluntarily cancels coverage (30-day advance written notice required), is unable (after being given at least a 30-day notice) to meet eligibility requirements to maintain a group plan, or still does not pay the required health care premium (after being given a 31-day grace period and at least a 15-day notice).
	•		we decide to no longer offer the specific plan chosen by your employer (you'll get a 90-day advance notice) or if we decide to no longer offer any coverage in Virginia (you'll get a 180-day advance notice).
		•	your employer and you received a 30-day advance written notice that the coverage was being changed (services added to your plan or the copayment amounts decreased). Copayments can be increased or services can be decreased only when it is time for your group to renew its KeyCare coverage.

2. **On an individual level** — factors that apply to you and covered family members — your KeyCare plan can be…

renewed	cancelled	when…
•		you maintain your eligibility for coverage with your employer, pay your required portion of the health care premium and do not commit fraud or misrepresent yourself.
	•	you purposely give wrong information about yourself or your dependents when you enroll. Cancellation is effective immediately.
	•	you lose your eligibility for coverage, don't make required payments or make bad payments, commit fraud, are guilty of gross misbehavior, don't cooperate with coordination of benefits recoveries, let others use your ID card, use another member's ID card or file false claims with us. Your coverage will be cancelled after you receive a written notice from us.

SPECIAL ENROLLMENT PERIODS

Typically you are only allowed to enroll in your employer's health plan during certain eligibility periods, such as when it is first offered to you as a "new hire" or during your employer's open enrollment period when employees can make changes to their benefits for an upcoming year. But there may be cases other than these situations in which you may be eligible to enroll. For example, if the first time you are offered coverage and you state in writing that you don't want to enroll yourself, your spouse or your covered dependents because you have coverage through another carrier or group health plan, you may be able to enroll your family later if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). But, you must ask to be enrolled within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact your employer.

ABOUT PRE-EXISTING CONDITIONS

When You First Enroll *(for groups with less than 500 employees)*

Have you been treated for or diagnosed as having a specific condition other than pregnancy? If you have been, did the diagnosis or treatment occur less than 6 months before the date you will begin coverage under your employer's group health plan or by the start of the waiting period required by your employer, whichever is earlier? If so, there is a 12-month period when services may* not be covered for those specific conditions — often called "pre-existing conditions." All other covered services not related to the pre-existing conditions will be available beginning on your first day as a KeyCare member. If you or a covered family member have had breast cancer and have been disease free for five years, it is not considered a pre-existing condition, even if you have had routine follow-up visits to monitor for reoccurrence within the past 6 months or during your employer's required waiting period.

* Your 12-month pre-existing period can be reduced by the number of months of "creditable coverage" you had before your group health plan coverage (or employer-required waiting period) starts. Creditable coverage is earned by having had coverage under most types of group or individual:

- health insurance programs
- HMO plans
- health service plans
- fraternal society plans, or
- publicly-sponsored plans like Medicare, Medicaid, State Children's Health Insurance Program (S-CHIP) or TRICARE

You should receive proof of prior coverage (called a "certificate of creditable coverage") from either the employer with whom you had the coverage or the health care company that provided it. If you go more than 63 days without health care coverage, coverage before that 63-day break will not reduce your pre-existing period. So that we may reduce the pre-existing period by the amount of time you were covered under creditable coverage, we may require you to give us a copy of any certificates of creditable coverage that you have. If you do not have a certificate, but you have creditable coverage, we will help you get one from your prior plan or issuer. Contact Member Services either by phone or by the address listed on the back of this enrollment brochure.

Want a recap on what we just explained? See the chart below.

No waiting period	Reduction in the 12-month waiting period	when...
•		your employer has at least 10 employees and is switching your coverage to KeyCare and you have been enrolled under your employer's previous health care plan.
•		a baby, within 30 days of birth, has been covered under a group or individual insurance or HMO plan, service plan, fraternal plan, or a publicly-sponsored plan like Medicare, Medicaid or TRICARE or other plan described in the member booklet.
•		children you have adopted or are going to adopt are under the age of 18 and · have been covered under a group insurance or HMO plan, a government plan (Medicare, Medicaid, TRICARE or other similar publicly-sponsored program) or other plan described in the member booklet within 30 days of the adoption or placement and did not go more than 63 days without coverage, and · will be enrolled in your KeyCare coverage within 30 days of their initial eligibility. Otherwise, they may not be eligible to enroll in your plan for up to one year.
	•	you have just joined an employer who has been offering KeyCare coverage and you were covered by another health plan before enrolling in your new employer's KeyCare plan. Often the waiting period will be reduced by the number of months you were covered under your former employer's plan.

HOW WE ESTABLISH OUR RATES

Factors used to set the price of health care coverage for employers with 2-99 employees:

- the KeyCare plan selected by your employer
- your employer's location
- the age and gender of each employee
- the number of enrolled employees
- the number of dependents enrolled by each employee
- the health status of the enrolled employees and their dependents

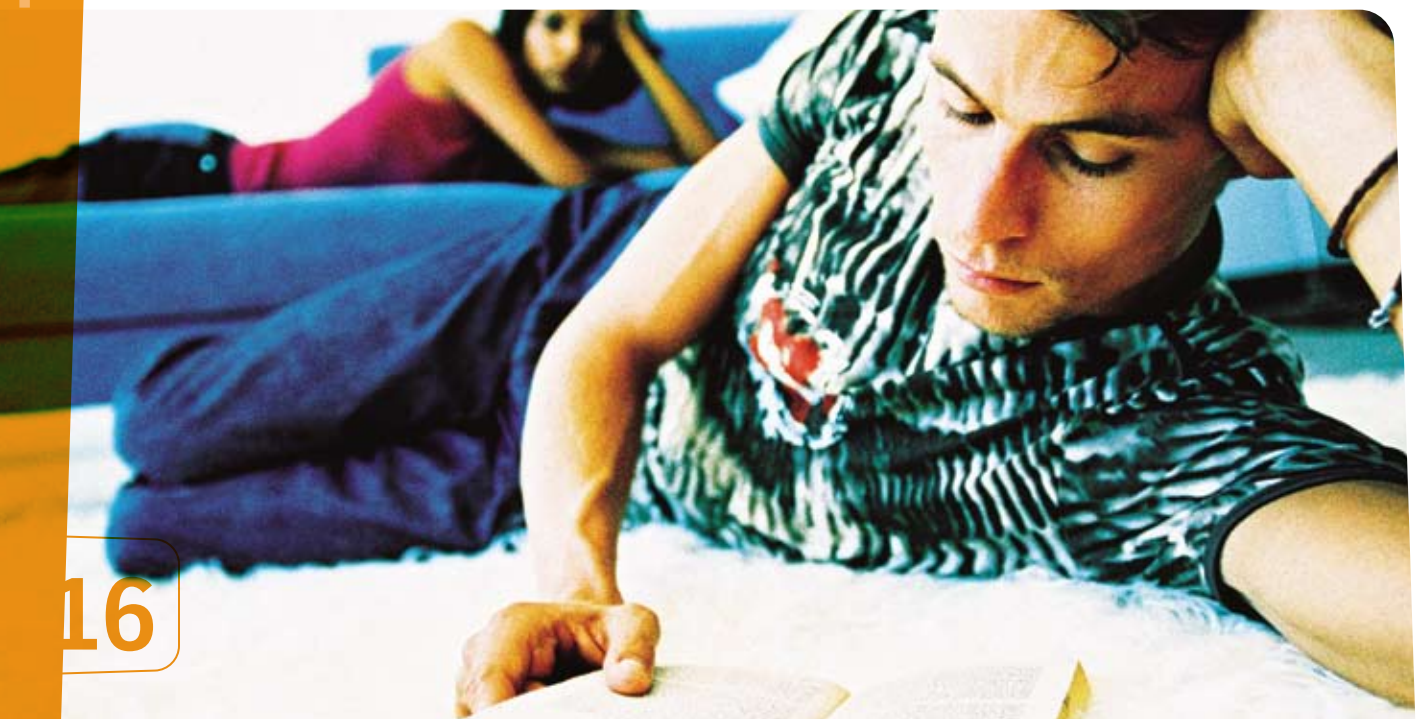
Additional factors for employers with 15-99 employees:

- your employer's industry

WHEN YOU'RE COVERED BY MULTIPLE PLANS

If you're fortunate enough to be covered by more than one health plan, you may not be so thrilled about the paper work hassles that can come with it when you're trying to figure out which plan should pay for what. Our Coordination of Benefits (COB) program helps ensure that you receive the benefits due and avoid overpayment by either carrier. Because up-to-date, accurate information is the key to our Coordination of Benefits program, you can expect to receive a COB questionnaire on an annual basis. Timely response to these questionnaires will help avoid delays in claims payment.

If you are covered by two different group health plans, one is considered primary and the other is considered secondary. The primary carrier is the first to pay a claim and provide reimbursement according to plan allowances; the secondary carrier then provides reimbursement, typically covering the remaining allowable expenses.



DETERMINING THE PRIMARY VERSUS SECONDARY CARRIER

See the chart below for how determination gets made over which health plan is the primary carrier. The term "participant" is used and means the person who is signing up for coverage:

When a person is covered by 2 group plans, and	Then	Primary	Secondary
One plan does not have a COB provision	The plan without COB is	●	
	The plan with COB is		●
The person is the participant under one plan and a dependent under the other	The plan covering the person as the participant is	●	
	The plan covering the person as a dependent is		●
The person is the participant in two active group plans	The plan that has been in effect longer is	●	
	The plan that has been in effect the shorter amount of time is		●
The person is an active employee on one plan and enrolled as a COBRA participant for another plan	The plan in which the participant is an active employee is	●	
	The COBRA plan is		●
The person is covered as a dependent child under both plans	The plan of the parent whose birthday occurs earlier in the calendar year (known as the birthday rule) is	●	
	The plan of the parent whose birthday is later in the calendar year is		●
	Note: When the parents have the same birthday, the plan that has been in effect longer is	●	
The person is covered as a dependent child and coverage is stipulated in a court decree	The plan of the parent primarily responsible for health coverage under the court decree is	●	
	The plan of the other parent is		●
The person is covered as a dependent child and coverage is not stipulated in a court decree	The custodial parent's plan is	●	
	The non-custodial parent's plan is		●
The person is covered as a dependent child and the parents share joint custody	The plan of the parent whose birthday occurs earlier in the calendar year is	●	
	The plan of the parent whose birthday is later in the calendar year is		●
	Note: When the parents have the same birthday, the plan that has been in effect longer is	●	

HOW BENEFITS APPLY WHEN MEDICARE-ELIGIBLE

Some people under age 65 are eligible for Medicare in addition to any other coverage they may have. The following chart shows how payment is coordinated under various scenarios:

When a person is covered by Medicare and a group plan, and	Then	KeyCare is Primary	Medicare is Primary
Is a person who is qualified for Medicare coverage due solely to End Stage Renal Disease (ESRD-kidney failure)	During the 30-month Medicare entitlement period	•	
	Upon completion of the 30-month Medicare entitlement period		•
Is a disabled member who is allowed to maintain group enrollment as an active employee	If the group plan has more than 100 participants	•	
	If the group plan has fewer than 100 participants		•
Is the disabled spouse or dependent child of an active full-time employee	If the group plan has more than 100 participants	•	
	If the group plan has fewer than 100 participants		•
Is a person who becomes qualified for Medicare coverage due to ESRD after already being enrolled in Medicare due to disability	If Medicare had been secondary to the group plan before ESRD entitlement	•	
	If Medicare had been primary to the group plan before ESRD entitlement		•

RECOVERY OF OVERPAYMENTS

If health care benefits are inadvertently overpaid, reimbursement for the overpayment will be requested. Your help in the recovery process would be appreciated. We reserve the right to recover any overpayment from:

- any person to or for whom the overpayments were made;
- any health care company; and
- any other organization.

WHAT'S NOT COVERED (EXCLUSIONS)

When it comes to your health, you're the final decision maker about what services you need to get and where you should get them from. But, in order for us to keep the cost of health care as low as possible for both you and your employer, we have to exclude certain services. The following list of services and supplies are excluded from coverage by your health plan and will not be covered in any case.

acupuncture

biofeedback therapy

over-the-counter **convenience** and hygienic items including, but not limited to, adhesive removers, cleansers, underpads, and ice bags

cosmetic surgery or procedures, including complications that result from such surgeries and/or procedures. Cosmetic surgeries and procedures are performed mainly to improve or alter a person's appearance including body piercing and tattooing. However, a cosmetic surgery or procedure does not include a surgery or procedure to correct deformity caused by disease, trauma, or a previous therapeutic process. Cosmetic surgeries and/or procedures also do not include surgeries or procedures to correct congenital abnormalities that cause functional impairment. We will not consider the patient's mental state in deciding if the surgery is cosmetic.

no **dental** services except:

- medically necessary dental services resulting from an accidental injury, provided that, for an injury occurring on or after your effective date of coverage, you seek treatment within 60 days after the injury. You must submit a plan of treatment from your dentist or oral surgeon for prior approval by Anthem.
- cost of dental services and dental appliances only when required to diagnose or treat an accidental injury to the teeth
- repair of dental appliances damaged as a result of an accidental injury to the jaw, mouth or face
- dental services and appliances furnished to a newborn when required to treat medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia
- dental services to prepare the mouth for radiation therapy to treat head and neck cancer
- covered general anesthesia and hospitalization services for children under the age of 5, covered persons who are severely disabled, and covered persons who have a medical condition that requires admission to a hospital or outpatient surgery facility. These services are provided when it is determined by a licensed dentist, in consultation with the covered persons' treating physician that such services are required to effectively and safely provide dental care.

donor searches for organ and tissue transplants, including compatibility testing of potential donors who are not immediate, blood-related family members (parent, child, sibling)

educational or teacher services except in limited circumstances

experimental/investigative procedures, as well as services related to or complications from such procedures except for clinical trial costs for cancer as described by the National Cancer Institute. This will not prevent a member from being able to appeal Anthem's decision that a service is not experimental/investigative.

F-M

EXPERIMENTAL... OR NOT?

Many of the Anthem medical directors and staff actively participate in a number of national health care committees that review and recommend new experimental or investigative treatments for coverage. To be approved for coverage, the service or product must have:

- regulatory approval from the Food and Drug Administration;
- been put through extensive research study to find all the benefits and possible harms of the technology;
- benefits that are far better than any potential risks;
- at least the same or better effectiveness as any similar service or procedure already available; and
- been tested enough so that we can be certain it will result in positive results when used in real cases.

family planning
- birth control medicine and devices unless prescribed for reasons other than birth control
- services for artificial insemination or in vitro fertilization or any other types of artificial or surgical means of conception including any drugs administered in connection with these procedures
- drugs used to treat infertility
- reversals of sterilization

services for palliative or cosmetic **foot** care
- flat foot conditions
- support devices, arch supports, foot inserts, orthopedic and corrective shoes that are not part of a leg brace and fittings, castings and other services related to devices of the feet
- foot orthotics
- subluxations of the foot
- corns
- bunions (except capsular or bone surgery)
- calluses
- care of toenails
- fallen arches
- weak feet
- chronic foot strain
- symptomatic complaints of the feet

hearing care except in relation to preventive care screenings (Implantable or removable hearing aids, except for cochlear implants, are not covered.)

home care services
- homemaker services
- maintenance therapy
- food and home delivered meals
- custodial care and services

hospital services
- guest meals, telephones, televisions, and any other convenience items received as part of your inpatient stay
- care by interns, residents, house physicians, or other facility employees that are billed separately from the facility
- a private room unless it is medically necessary

maternity benefits for your unmarried dependent children

medical equipment, appliances and devices, and medical supplies that have both a non-therapeutic and therapeutic use:
- exercise equipment
- air conditioners, dehumidifiers, humidifiers, and purifiers
- hypoallergenic bed linens
- whirlpool baths

These services are excluded from your KeyCare plan.

- handrails, ramps, elevators, and stair glides
- telephones
- adjustments made to a vehicle
- foot orthotics
- changes made to a home or place of business
- repair or replacement of equipment you lose or damage through neglect

medical equipment (durable) that is not appropriate for use in the home

services or supplies deemed **not medically necessary** as determined by Anthem at its sole discretion. This will not prevent a member from being able to appeal Anthem's decision that a service is not medically necessary.

The following exceptions qualify for coverage.
For inpatients:

1. services rendered by professional providers who do not control whether you are treated on an inpatient basis, such as pathologists, radiologists, anesthesiologists, and consulting physicians or related outpatient services or as part of your outpatient services will not be denied under this exclusion in spite of the medical necessity denial of the overall services

2. services rendered by your attending provider other than inpatient evaluation and management services. Inpatient evaluation and management services include routine visits by your attending provider to review patient status, test results, and patient medical records and do not include surgical, diagnostic, or therapeutic services.

For outpatients:
services of pathologists, radiologists and anesthesiologists rendering services in an (i) outpatient hospital setting, (ii) emergency room, or (iii) ambulatory surgery setting. This exception does not apply if and when pathologist, radiologist or anesthesiologist assumes the role of attending physician.

mental health and substance abuse

- inpatient stays for environmental changes
- cognitive rehabilitation therapy
- educational therapy
- vocational and recreational activities
- coma stimulation therapy
- services for sexual deviation and dysfunction
- treatment of social maladjustment without signs of a psychiatric disorder
- remedial or special education services
- inpatient mental health treatments that meet the following criteria:
  - more than 2 hours of psychotherapy during a 24-hour period in addition to the psychotherapy being provided pursuant to the inpatient treatment program of the hospital
  - group psychotherapy when there are more than 8 patients with a single therapist
  - group psychotherapy when there are more than 12 patients with two therapists
  - more than 12 convulsive therapy treatments during a single admission
  - psychotherapy provided on the same day of convulsive therapy

N-S

nutrition counseling and related services, except when provided as part of diabetes education

obesity services and supplies related to weight loss or dietary control, including complications that directly result from such surgeries and/or procedures. This includes weight reduction therapies/activities, even if there is a related medical problem. Notwithstanding provisions of other exclusions involving cosmetic surgery to the contrary, services rendered to improve appearance (such as abdominoplasties, panniculectomies, and lipectomies), are not covered services even though the services may be required to correct deformity after a previous therapeutic process involving gastric bypass surgery.

organ or tissue transplants, including complications caused by them, except when they are considered medically necessary, have received pre-authorization, and are not considered experimental/investigative. Autologous bone marrow transplants for breast cancer are covered only when the procedure is performed in accordance with protocols approved by the institutional review board of any United States medical teaching college. These include, but are not limited to, National Cancer Institute protocols that have been favorably reviewed and used by hematologists or oncologists who are experienced in high dose chemotherapy and autologous bone marrow transplants or stem cell transplants. This procedure is covered despite the exclusion in the plan of experimental/investigative services.

paternity testing

prescription drug benefits

- birth control medications and devices
- over-the-counter drugs
- any per unit, per month quantity over the plan's limit
- drugs used mainly for cosmetic purposes
- drugs that are experimental, investigational, or not approved by the FDA
- cost of medicine that exceeds the allowable charge for that prescription
- drugs for weight loss
- stop smoking aids
- therapeutic devices or appliances
- injectable prescription drugs that are supplied by a provider other than a pharmacy
- charges to inject or administer drugs
- drugs not dispensed by a licensed pharmacy
- drugs not prescribed by a licensed provider
- any refill dispensed after one year from the date of the original prescription order
- medicine covered by workers' compensation, Occupational Disease Law, state or government agencies
- medicine furnished by any other drug or medical service

private duty nurses in the inpatient setting

rest cures, custodial, residential or domiciliary care and services. Whether care is considered residential will be determined based on factors such as whether you receive active 24-hour skilled professional nursing care, daily physician visits, daily assessments, and structured therapeutic service.

care from **residential treatment centers** or other non-skilled sub-acute inpatient settings, except to the extent such setting qualified 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

services or supplies

- ordered by a doctor whose services are not covered under your health plan
- care of any type given along with the services of an attending provider whose services are not covered
- not listed as covered under your health plan
- not prescribed, performed, or directed by a provider licensed to do so
- received before the effective date or after a covered person's coverage ends
- telephone consultations, charges for not keeping appointments, or charges for completing claim forms

services or supplies

- for travel, whether or not recommended by a physician
- given by a member of the covered person's immediate family
- provided under federal, state, or local laws and regulations including Medicare and other services available through the Social Security Act of 1965, as amended, except as provided by the Age Discrimination Act. This exclusion applies whether or not you waive your rights under these laws and regulations. It does not apply to laws that make the government program the secondary payor after benefits under this policy have been paid. Anthem will pay for covered services when these program benefits have been exhausted.
- provided under a U.S. government program or a program for which the federal or state government pays all or part of the cost. This exclusion does not apply to health benefits plans for civilian employees or retired civilian employees of the federal or state government
- received from an employer mutual association, trust, or a labor union's dental or medical department
- for diseases contracted or injuries caused because of war, declared or undeclared, voluntary participation in civil disobedience, or other such activities

services for which a charge is not usually made including those services for which you would not have been charged if you did not have health care coverage

services or benefits for:

- amounts above the allowable charge for a service
- self-administered services or self care
- self-help training
- biofeedback, neurofeedback, and related diagnostic tests

sexual dysfunction surgery or sex transformation services, including medical and mental health services

skilled nursing facility stays

- treatment of psychiatric conditions and senile deterioration
- facility services during a temporary leave of absence from the facility
- a private room unless it is medically necessary

S-W

smoking cessation, including stop smoking aids or services of stop smoking clinics

spinal manipulations or other manual medical interventions for an illness or injury other than musculoskeletal conditions

therapies

- physical therapy, occupational therapy, or speech therapy to maintain or preserve current functions if there is no chance of improvement or reversal except for children under age 3 who qualify for early intervention services
- group speech therapy
- group or individual exercise classes or personal training sessions
- recreation therapy including, but not limited to, sleep, dance, arts, crafts, aquatic, gambling, and nature therapy

vision services

- vision services or supplies unless needed due to eye surgery and accidental injury
- routine vision care and materials
- services for radial keratotomy and other surgical procedures to correct refractive defects such as nearsightedness, farsightedness and/or astigmatism. This type of surgery includes keratoplasty and Lasik procedure;
- services for vision training and orthoptics
- tests associated with the fitting of contact lenses unless the contact lenses are needed due to eye surgery or to treat accidental injury
- sunglasses or safety glasses and accompanying frames of any type
- any non-prescription lenses, eyeglasses or contacts, or Plano lenses or lenses that have no refractive power
- any lost or broken lenses or frames
- any blended lenses (no line), oversize lenses, progressive multifocallenses, photchromatic lenses, tinted lenses, coated lenses, cosmetic lenses or processes, or UV-protected lenses
- services needed for employment or given by a medical department, clinic, or similar service provided or maintained by the employer or any government entity
- any other vision services not specifically listed as covered

services or supplies if they are for **work-related** injuries or diseases when the employer must provide benefits by federal, state, or local law or when that person has been paid by the employer. This exclusion applies even if you waive your right to payment under these laws and regulations or fail to comply with your employer's procedures to receive the benefits. It also applies whether or not the covered person reaches a settlement with his or her employer or the employer's insurer or self insurance association because of the injury or disease.