



Key Advantage With Expanded Benefits

Notification of Changes to Your Member Handbook
The Local Choice Health Benefits Program

This booklet consolidates notifications to the Key Advantage With Expanded health benefits plan from July 1, 2001 through July 1, 2003 and October 1, 2003 for some school groups. You may replace individual notification documents with this consolidated booklet. Keep this booklet with your Key Advantage Member Handbook, #T20073 (7/00) for a full and complete description of your coverage. You or your Benefits Administrator may view and print this Member Handbook from The Local Choice Web site at www.thelocalchoice.state.va.us or from Anthem Blue Cross and Blue Shield's site at www.anthem.com.

- 1) **The requirement to choose a primary care physician in order to receive the highest level of covered benefits, and the requirement that your primary care physician refer you to a specialist for care not rendered by your primary care physician has been removed. All references to payment levels reduced by 25 percentage points for covered services rendered without a referral no longer apply. Effective July 1, 2003**

Page 5 – Services of a Primary Care Physician
Page 62 – Definitions (Referral)

- 2) **Under Hospital Services, payment will no longer be reduced by \$500 if the Participant fails to comply with the Hospital admission review procedures. Effective July 1, 2003**

Page 14 – Hospital Services/Copayments and Coinsurance

- 3) **The BlueCard[®] program has been added to your plan, as follows: Effective July 1, 2003**

BlueCard[®] PPO for Care within the United States

If you need medical care outside the Anthem network and within the United States, you will have access to care from a BlueCard PPO provider. Through the BlueCard PPO program, your Anthem Blue Cross and Blue Shield ID card is accepted by physicians and hospitals throughout the country who participate with another Blue Cross Blue Shield company. These providers accept your copayment or coinsurance at the time of service instead of requiring full payment. They file claims directly to their local Blue Cross Blue Shield company for you, and have agreed to accept the allowable charge established by the local company as payment in full.

To locate a BlueCard PPO physician or hospital call **1-800-810-BLUE (2583)**. Or use the BlueCard Doctor and Hospital Finder on the Web at www.bcbs.com. Providers can also tell you if they participate in BlueCard PPO when you call to make an appointment.

Simply present your Anthem ID card when you receive care. The PPO suitcase logo at the top of your card tells the physician or hospital that your COVA Care plan includes the BlueCard PPO program.

How Charges Are Calculated for BlueCard PPO Services

The amount used to calculate your payment responsibility for a covered service will usually be the lower of:

- The billed charge for the covered service; or
- The negotiated price passed on to Anthem through the BlueCard program.

Often, this “negotiated price” will consist of a simple discounted price. It can also be an estimated or average price allowed by the BlueCard program and the terms of your health care plan. An estimated price takes into account special arrangements with a provider or provider group that include settlements, withholds, non-claims transactions (such as provider advances) and other types of variable payments. An average price is based on a discount that takes into account these same special arrangements. Of the two, estimated prices are usually closer to the actual prices. Negotiated prices may be adjusted going forward to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Laws in a small number of states may require the local Blue Cross and/or Blue Shield plan to use another method for calculating the charge, or add a surcharge to your liability calculation. In these states, Anthem Blue Cross and Blue Shield would calculate your liability according to the applicable state law in effect when you received care.

BlueCard Worldwide® for Care outside the United States

If you live or travel outside the United States, the BlueCard Worldwide program assists you to obtain inpatient and outpatient hospital care and physician services.

Follow these steps *before* you travel:

1. Obtain a list of BlueCard Worldwide hospitals located where you will be traveling or staying. You may obtain this information on the Web at www.bcbs.com. Select Healthcare Anywhere on the home page. Or you may call **1-800-810-BLUE (2583)** for assistance.
2. Be sure to carry your Anthem medical ID card with you and present it when you need inpatient care.

If you need care once you arrive at your destination, follow these simple steps:

Inpatient Hospital Care

Non-emergency:

1. Call the Service Center at **1-800-810-BLUE** or call collect to **(804) 673-1177**. A BlueCard Worldwide Service Center representative will accept the charges and will facilitate hospitalization at a BlueCard Worldwide hospital. It is important that you call the Service Center in order to obtain cash-less access for inpatient care. The hospital will submit your claim for you. The Service Center is staffed with multilingual representatives and is available 24 hours a day, seven days a week.
2. Call Anthem at **1-800-242-7277** for hospital admission review.

Emergency:

Bypass the above steps. Go to the nearest hospital. Call the Service Center at **1-800-810-BLUE** or call collect to **(804) 673-1177** if you are admitted to arrange cash-less access (available in most cases). A BlueCard Worldwide Service Center representative will assist you. A family member or friend can make this call for you.

Outpatient Hospital Care/Physician Services

1. Call **1-800-810-BLUE** or call collect to **(804) 673-1177**. A BlueCard Worldwide Service Center representative will accept the charges and will make an appointment with a doctor for you, or will direct you to a hospital.
2. You will need to pay for your care and then submit a claim using the International Claim Form to the BlueCard Worldwide Service Center (address is on the claim form). Contact the Service Center for the form, or you may download the form on the Web at www.bcbs.com. Select Healthcare Anywhere on the home page.

4) The process for appealing a medical claim has been changed as described below:

Effective July 1, 2003

Complaint and Appeal Process

In order for your health plan to remain responsive to your needs, we have established both a complaint process and an appeal process. Should you have a problem or question about your health plan, a Member Services representative will assist you. Most problems and questions can be handled in this manner. You may also file a written complaint or appeal with us. Complaints typically involve issues such as dissatisfaction about your health plan's services, quality of care, the choice and accessibility to your health plan's providers and network adequacy. Appeals typically involve a request to reverse a previous decision made by your health plan. Requests regarding claim errors, claim corrections, and claims denied for additional information may be reopened for consideration without having to invoke the appeal process.

Complaint Process

Upon receipt, your complaint will be reviewed and investigated. You will receive a response within 30 calendar days of your health plan's receipt of your complaint. If we are unable to resolve your complaint in 30 calendar days, you will be notified on or before calendar day 30 that more time is required to resolve your complaint. We will then respond to you within an additional 30 calendar days. **Important:** Written complaints or any questions concerning your health insurance may be filed to the following address:

Anthem Blue Cross and Blue Shield
Attention: Member Services
P. O. Box 27401
Richmond, VA 23279

Appeal Process

Your health plan is committed to providing a full and fair process for resolving disputes and responding to requests to reconsider coverage decisions you find unacceptable. There are two types of appeals:

- Internal appeals are requests to reconsider coverage decisions of pre-service (prior authorization) or post-service claims. Expedited appeals involve requests to reconsider coverage decisions where the application of pre-service or post-service time periods for mailing appeal decisions could seriously jeopardize the patient's life, health or ability to regain maximum function, or in the opinion of the patient's physician, would subject the patient to severe pain; and
- External appeals are requests for an independent, external review of the final coverage decision made by your health plan through its internal appeal process. More information about this type of appeal may be found in the "External Appeals" paragraph of this section.

How to appeal a coverage decision

To appeal a coverage decision, please send a written explanation of why you feel the coverage decision was incorrect. Alternatively, this information may be provided to a Member Services representative over the phone. This is your opportunity to provide any new information that you feel your health plan should consider when reviewing your appeal. Please include with the explanation:

- the patient's name, address and telephone number;
- your identification and group number (as shown on your identification card); and
- the name of the health care professional or facility that provided the service, including the date and description of the service provided and the charge.

Important: You may contact Member Services with your appeal or any questions concerning your health insurance at the following address:

Anthem Blue Cross and Blue Shield
Attention: Corporate Appeals Department
P. O. Box 27401
Richmond, VA 23279

Telephone:
(804) 355-8506 in Richmond
800-552-2682 outside Richmond

You must file your appeal within either 15 months of the date of service or 180 days of the date you were notified of the adverse benefit determination, whichever is later.

How your health plan will handle your appeal

In reviewing your appeal, we will take into account all the information you submit, regardless of whether the information was considered at the time the initial coverage decision was made. A review will be completed, and will not assume the correctness of the original determination. The individual reviewing your appeal will not have participated in the original coverage decision, and will not be a subordinate of the individual who made the original determination. Appeals involving medical necessity will be reviewed by an actively practicing practitioner from the same or similar specialty who typically treats the medical condition or provides the procedure or treatment in question, and is not employed by or as a director of your health plan. An actively practicing practitioner is an individual who provides direct patient care, is board certified or board eligible, and is licensed to practice in Virginia or under similar licensing laws. Any other decision that involves the review of medical information will be made by appropriate clinical staff.

Upon receipt of your appeal, the Appeal Coordinator who has been assigned to your appeal will send you a confirmation letter within 5 business days. We will resolve and respond in writing to your appeal within the following time frames.

- 30 days from the receipt of the request to appeal a pre-service (prior authorization) claim;
- 60 days from the receipt of the request to appeal a post-service claim; or
- 1 working day from the receipt of the request to appeal, if an expedited appeal was requested by the member or the treating provider.

When our review of your appeal has been completed, you will receive written notification of the outcome. In the event that the original coverage decision is upheld, the written notification will include the specific reasons and the plan provision(s) on which the determination is based. You will also be entitled to receive, upon request and at no charge, the following:

- reasonable access to, and copies of, all documents, records, and other information relevant to the appeal;
- any rule, guideline, protocol or criterion relied upon in the coverage decision(s);
- the explanation of the scientific or clinical judgment as it relates to the patient's medical condition if the coverage decision was based on the medical necessity or experimental nature of the care; and
- the identification of medical or vocational experts whose advice was obtained by the plan in connection with the claimant's adverse decision, whether or not the advice was relied upon.

External appeals

To appeal the final coverage decision made by your health plan through its internal appeal process, you must submit to the Commonwealth of Virginia's director of the Department of Human Resource Management in writing, within 60 days of your health plan's denial, the following:

- your full name;
- your identification number;
- the date of the service;
- the name of the provider for whose services payment was denied; and
- the reason you think the claim should be paid.

You are responsible for providing the Department of Human Resource Management with all information necessary to review the denial of your claim. The Department of Human Resource Management will ask you to submit any additional information you wish to have considered in this review, and will give you the opportunity to explain, in person or by telephone, why you think the claim should be paid. Claims denied due to such things as contractual or eligibility issues will be reviewed by the director. Claims denied because the treatment provided was considered not medically necessary will be referred to an independent medical review organization.

Review for treatment authorizations or medical claims that have been denied will be sent to an impartial health entity. The impartial health entity shall examine the final denial of claims or treatment authorizations to determine whether the decision is objective, clinically valid, and comparable with established principles of health care. The decision of the impartial health entity shall:

- be in writing;
- contain findings of fact as to the material issues in the case and the basis for those findings; and
- be final and binding if consistent with law and policy.

If, after review, the claim remains denied, that denial is final, unless you appeal that determination within 30 days as provided under the Administrative Process Act. You may obtain an external appeals form on the Web at www.thelocalchoice.state.va.us.

Notice in writing

Any notice required under this health plan must be in writing. Notice given to your employer will be sent to your employer's address, stated in the group application as provided by the group. Notice given to a covered person will be sent, at our option, to the plan administrator or to your address as it appears on our records. Anthem, the plan administrator, or a covered person may indicate a new address for giving notice.

Page 7 – Appeals

5) The following paragraph is added to item 6) Prompt Filing Claims, under the Basic Plan Provisions section: Effective July 1, 2003

Your health plan may deny a claim for benefits if information needed to fully consider the claim is not provided. The denial will describe the additional information needed to process the claim. The claim may be reopened by you or the provider furnishing the additional information. You or your provider must submit the additional information to us within either 15 months of the date of service or 45 days from the date you were notified that the information is needed, whichever is later. Once your claim has been processed by your health plan, you will receive written notification of the coverage decision.

Page 46 – Prompt Filing of Claims

6) Under Eligibility, the Dependents section regarding unmarried biological and adopted children, and disabled children, is changed as follows: Effective July 1, 2003

Unmarried biological and adopted children may be covered by the The Local Choice Health Benefits Program to the end of the year in which they turn age 23 if the child lives at home and can be claimed on the parent's federal income tax return. There are limited circumstances which would allow eligibility under the plan even if the child does not live at home. Examples include:

- The child lives with the other parent if the employee is divorced, and
- The child lives away from home while attending college or boarding school.

Disabled adult children may be covered if the qualifying disability was diagnosed prior to the loss of eligibility for coverage due to age and has been approved by the plan administrator. Enrollment must occur within 31 days of loss of coverage as dependent children due to age. **A child who later recovers is no longer eligible and may not re-enroll.**

Children who are age 19 or older may not be covered by The Local Choice Health Benefits Program if they are not eligible to be claimed on the employee's income tax return as a dependent (i.e., children who are self-supporting).

Page 64 – Eligibility, Dependents

7) Routine mammogram coverage has been changed to cover one routine screening mammogram each year for members age 35 and older. Effective July 1, 2003

Page 12 – Institutional Services, item 6)
Page 23 – Professional Services, item 2)

8) The following laboratory services shown under Professional Services are also covered under Institutional Services: Effective July 1, 2003

- One annual Pap smear
- One annual routine prostate specific antigen (PSA) test (age 40 and over)
- Colorectal cancer screenings for members age 40 and over as outlined: one annual fecal occult blood test, and one annual flexible sigmoidoscopy, or colonoscopy or double contrast barium enema

Page 11 – Institutional Services

9) Certain drugs may not be available through the mail service (home delivery) pharmacy due to distribution restrictions imposed by the drug manufacturer. However, these drugs are available through the network retail pharmacies at their appropriate retail copayment level. Benefit Clarification July 1, 2003

Page 31 – Outpatient Prescription Drugs

10) Disclosure of Protected Health Information to the Employer Effective April 14, 2003

(1) Definitions. Whenever used in this Article, the following terms shall have the respective meanings set forth below.

- (a) Plan-means the “State and Local Health Benefits Programs.”
- (b) Employer-means the local employer group
- (c) Plan Administration Functions-means administrative functions performed by the Employer on behalf of the Plan, excluding functions performed by the Employer in connection with any other benefit or benefit plan of the Employer.
- (d) Health Information-means information (whether oral or recorded in any form or medium) that is created or received by a health care provider, health plan (as defined by the Health Insurance Portability and Accountability Act of 1996, subsequently referred to as HIPAA, in 45 CFR § 160.103), employer, life insurer, school or university, or health care clearinghouse (as defined by HIPAA in 45 CFR § 160.103) that relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.
- (e) Individually Identifiable Health Information-means Health Information, including demographic information, collected from an individual and created or received by a health care provider, health plan, employer, or health care clearinghouse that identifies the TLC individual involved or with respect to which there is a reasonable basis to believe the information may be used to identify the individual involved.
- (f) Summary Health Information-means information that summarizes the claims history, expenses, or types of claims by individuals for whom the Employer provides benefits under the Plan, and from which the following information has been removed: (1) names; (2) geographic information more specific than state; (3) all elements of dates relating to the individual(s) involved (e.g., birth date) or their medical treatment (e.g., admission date) except the year; all ages for those over age 89

and all elements of dates, including the year, indicative of such age (except that ages and elements may be aggregated into a single category of age 90 and older); (4) other identifying numbers, such as Social Security, telephone, fax, or medical record numbers, e-mail addresses, VIN, or serial numbers; (5) facial photographs or biometric identifiers (e.g., finger prints); and (6) any information the Employer does not have knowledge of that could be used alone or in combination with other information to identify an individual.

- (g) Protected Health Information ("PHI") means Individually Identifiable Health Information that is transmitted or maintained electronically, or any other form or medium.
- (2) The Plan, and the agents acting on its behalf, may disclose Summary Health Information to the Employer if the Employer requests such information for the purpose of obtaining premium bids for providing health insurance coverage under the Plan or for modifying, amending, or terminating the Plan.
- (3) The Plan, and the agents acting on its behalf, will disclose PHI to the Employer only in accordance with HIPAA in 45 CFR § 164.504(f) and the provisions of this Section.
- (4) The Plan hereby incorporates the following provisions (a) through (j) to enable it to disclose PHI to the Employer and acknowledges receipt of written certification from the Employer that of their intent to abide by these provisions.

Additionally, the Employer agrees:

- (a) not to use or further disclose PHI other than as permitted in Section (4) or as required by law;
- (b) to ensure that any of its agents or subcontractors to whom it provides PHI received from the Plan agree to the same restrictions and conditions;
- (c) not to use or disclose PHI for employment-related actions or in connection with any other benefit or employee benefit plan;
- (d) to report to the Plan any use or disclosure of the information that is inconsistent with the permitted uses and disclosures in Section (4);
- (e) to make PHI available to individuals in accordance with HIPAA in 45 CFR §164.524;
- (f) to make PHI available for individuals' amendment and incorporate any amendments in accordance with HIPAA in 45 CFR § 164.526;
- (g) to make the information available that will provide individuals with an accounting of disclosures in accordance with HIPAA in 45 CFR § 164.528;
- (h) to make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan and its agents available to the Department of Health and Human Services upon request; and
- (i) if feasible, to return or destroy all PHI received from the Plan that the Employer maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Employer will limit further its uses and disclosures of the PHI to those purposes that make the return or destruction of the information infeasible.

(j) to ensure that adequate separation between the Plan and the Employer, as required by HIPAA in 45 CFR § 164.504(f), is established and maintained.

(5) The Plan will disclose PHI only to the following employees or classes of employees:

- Director, Department of Human Resource Management
- Director of Finance, Department of Human Resource Management
- Employer's Executive Contact
- Employer's Benefits Administrator

Access to and use of PHI by the individuals described above shall be restricted to Plan Administration Functions that the Employer performs for the Plan. Such access or use shall be permitted only to the extent necessary for these individuals to perform their respective duties for the Plan.

(6) Instances of noncompliance with the permitted uses or disclosures of PHI set forth in this Section by individuals described in Section (5) shall be considered "failure to comply with established written policy" (a Group II offense) and must be addressed under the Commonwealth of Virginia's Policy 1.60, Standards of Conduct Policy. The appropriate level of disciplinary action will be determined on a case-by-case basis by the agency head or designee, with sanctions up to or including termination depending on the severity of the offense, consistent with Policy 1.60.

(7) A health insurance issuer, HMO or third party administrator providing services to the Plan is not permitted to disclose PHI to the Employer except as would be permitted by the Plan in this Article and only if a notice is maintained and provided as required by HIPAA in 45 CFR § 164.520.

11) The \$500 calendar limit for spinal manipulation and other manual medical intervention visits apply to a licensed chiropractor and any other licensed medical provider. Effective July 1, 2003

Page 29 – Chiropractic Services

12) Under Chiropractic Services, spinal manipulation and other manual intervention visits are limited to \$500 per calendar year. Effective July 1, 2002

Page 2 – Summary of Benefits
Page 29 – Chiropractic services

13) Exclusions, number 36) is replaced as follows: Effective October 1, 2002

Your coverage does not include benefits for services or supplies if they are deemed not **medically necessary** as determined by Anthem at its sole discretion.

However, if you receive inpatient or outpatient services that are denied as not medically necessary, or are denied for failure to obtain the required pre-authorization or primary care physician referral, the following professional provider services that you receive during your inpatient stay or as part of your outpatient services will not be denied under this exclusion in spite of the Medical Necessity denial of the overall services:

For Inpatients – 1) Services that are rendered by professional providers who do not control whether you are treated on an inpatient basis, such as pathologists, radiologists, anesthesiologists, and consulting physicians.

2) Services rendered by your Attending Provider other than inpatient evaluation and management services provided to you. Inpatient evaluation and management services include routine visits by your Attending Provider for purposes such as reviewing patient status, test results, and patient medical records. Inpatient

evaluation and management visits do not include surgical, diagnostic, or therapeutic services performed by your Attending Provider.

For Outpatients – Services of pathologists, radiologists and anesthesiologists.

Page 44 – Exclusions

14) Outpatient Prescription Drug Copayments change due to new three-tier structure:
Effective July 1, 2002

Network Retail Pharmacies

- Up to a 34-day supply* Changes from \$15 to Tier 1 - \$15; Tier 2 -\$20; Tier 3 - \$35

*You may purchase up to a 90-day supply at a network retail pharmacy by paying multiple copayments. For example, you pay two copayments for a 60-day or three copayments for a 90-day supply.

Mail Service Pharmacy

- Up to a 90-day supply Changes from \$23 to Tier 1 - \$18; Tier 2 - \$33; Tier 3 - \$63

Page 2 – Summary of Benefits

Page 32 – Copayments

15) Outpatient Prescription Drug Program Special Limits, number 1) under the 34-day supply from a retail pharmacy, the following limits are removed: 120 units or 500 milliliters of the drug, and two 10-milliliter vials of insulin.
Effective July 1, 2002

Page 31 – Special Limits

16) Outpatient Prescription Drug Program Special Limits, number 7) is replaced as follows:
Effective July 1, 2002

7) Prior authorization is required for certain medications. You will be notified in writing when a prescription is denied for coverage. Your physician will be notified of both approval and denial decisions.

Page 31 – Special Limits

17) Outpatient Prescription Drug Program Special Limits, number 8) i. – limitation removed.
Effective July 1, 2002

Page 31 – Special Limits

18) The Routine Vision benefit under the Optional Expanded Benefits changes as follows:
Effective July 1, 2002

Eyeglass frames	Plan payment changes from \$50 to <u>\$75</u>
Single vision lenses	Plan payment changes from \$35 to <u>\$50</u>
Bifocal lenses	Plan payment changes from \$50 to <u>\$75</u>
Trifocal lenses	Plan payment changes from \$70 to <u>\$100</u>
Contact lenses	Plan payment is unchanged at \$100

Benefits continue to be provided once every 24 months.

Page 2 – Summary of Benefits

Page 37 – Reimbursement

19) Under Major Medical Services, number 9) Dental services is replaced as follows:

Effective July 1, 2002

Dental services and dental appliances a provider furnishes are covered when required to treat medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia. Medically necessary dental services, resulting from an accidental injury while covered under the plan, are eligible for reimbursement if a plan of treatment from the dentist or oral surgeon is submitted to Trigon within 60 days of the date of the injury and subsequently approved. Dental services are also covered when required to diagnose or treat an accidental injury to the teeth if the accident occurs while the insured is covered under the plan. These services and appliances are covered for adults if rendered within a two-year period after the accidental injury.

The above two-year restriction may be waived for children under age 18. Actual treatment may be delayed if tooth/bone maturity is in question and standard industry protocols are followed. However, a treatment plan must be filed within 6 months of the accident and treatment must be completed within two years of active treatment commencement and prior to age 20. For the waiver to be granted, continuous coverage under the plan is required.

Major Medical Services include the repair of dental appliances damaged as a result of accidental injury to your jaw, mouth, or face. Injury as a result of chewing or biting will not be considered an accidental injury.

Page 38 – Services Which Are Eligible for Reimbursement

20) Under Eligibility, the Enrollment and Plan or Membership Changes section is replaced as follows:

Effective July 1, 2002

Procedures for Enrollment, Plan or Membership Changes, and effective dates for coverage, may be obtained from your employer.

Page 65 – Eligibility, Enrollment and Plan or Membership Changes

21) The section in the Code of Virginia pertaining to the The Local Choice Health Benefits Program was re-codified. As a result, the section reference is now §2.2-2818.

Effective October 1, 2001

Page 67 – Statutory Benefits

22) Under the Eligibility section of the Member Handbook, the Retired Employees and Surviving Dependents provision is replaced as follows:

Effective October 1, 2001

RETIRED EMPLOYEES

The Local Choice Group may elect to offer coverage to retirees and their eligible dependents.

- Non-Medicare eligible retirees may remain in the selected plan until reaching age 65 or eligibility for Medicare, whichever comes first.
- A Medicare supplement plan may be available to retirees upon enrollment in Medicare Parts A and B.
- Eligible dependents may be covered under either plan based on their Medicare status.
- Eligible dependent children of a retiree may be covered through the end of the year in which the child turns age 23 as long as the child is not self-supporting or married. Adult disabled children may be eligible for coverage based on TLC dependent eligibility guidelines.
- The Local Employer must offer coverage for non-Medicare eligible retirees if a Medicare supplement plan is offered.

SURVIVING DEPENDENTS OF RETIRED EMPLOYEES

The Local Choice Group may also elect to offer coverage to survivors of deceased retirees, if retiree coverage is offered.

- Health benefits for a covered surviving spouse and/or covered dependent children of a retired The Local Choice Group employee may be available through the Group's Retiree Health Benefits Program.

- ▶ Coverage for the surviving spouse automatically terminates at remarriage; alternate health insurance coverage being obtained; or any applicable condition outlined in the policies and procedures of the Department of Human Resource Management.
 - ▶ Coverage for any surviving dependent children in this category automatically terminates at death; at the end of the year in which the child turns age twenty three (unless eligible through disability); or if the child marries or becomes self-supporting. Loss of eligibility for a surviving spouse will result in the loss of eligibility for dependent children covered under the surviving spouse's membership.
- Special rules apply for dependents of employees who are disabled or killed in the line of duty. See Your Benefits Administrator for more information.

Page 65 – Retired Employees and Surviving Dependents

23) Outpatient hospital Copayment, including emergency room, changes from \$50 per Visit to \$75 per Visit. Effective July 1, 2001

Page 2 – Summary of Benefits
 Page 14 – Outpatient services
 Page 17 – Outpatient Hospital

24) Primary Care Physician (PCP) Copayment changes from \$13 per PCP Visit to \$15 per PCP Visit. Effective July 1, 2001

Page 2 – Summary of Benefits
 Page 20 – Home health services
 Page 26 – Maternity Services, and Other Outpatient care
 Page 27 – Colonoscopy
 Page 30 – Hospice care services

25) Colonoscopy does not require pre-authorization and is deleted from page 13, item 5). Effective July 1, 2001

26) Outpatient Prescription Drugs, page 31—Special Limits, item 8) e: Effective July 1, 2001

Prescription drugs prescribed for weight loss or as stop-smoking aids are excluded, **except for weight loss drugs prescribed in conjunction with the treatment of Morbid Obesity when the patient meets the definition of Morbid Obesity.**

SUMMARY OF KEY ADVANTAGE WITH EXPANDED BENEFITS

Effective July 1, 2003

The following table is an update to the Summary of Benefits on page 2 of your Member Handbook.

	Covered Services	In-Network You Pay
Inpatient Hospital	365 days per Confinement in semi-private room, or intensive care unit. Includes ancillary services.	\$200 per Confinement
Outpatient Hospital	Facility charge for outpatient department of a Hospital or Hospital emergency room	\$75 per Visit (waived if admitted)
Skilled Nursing Facility	180 days per Confinement in Network Skilled Nursing Facility	\$0
Home Health Care	90 Visits per calendar year	\$15 per PCP Visit; \$25 per specialist Visit
Professional Services	<ul style="list-style-type: none"> • Inpatient Physician care • Outpatient Physician Visit in office or Hospital <ul style="list-style-type: none"> ▪ Primary care ▪ Specialty care ▪ Maternity Services 	\$0 \$15 \$25 \$15 per PCP Visit; \$25 per specialist Visit
Physical/Speech/ Occupational Therapy	<ul style="list-style-type: none"> • Physical Therapy – authorized in advance by PCP • Speech and Occupational Therapy 	\$25 per specialist Visit
Chiropractic Services	Plan pays \$500 per calendar year for spinal manipulation and other manual intervention visits	\$25 per specialist Visit
Diagnostic Tests and Laboratory Services	Physician office, clinical reference lab, or outpatient hospital	10% AC*
Outpatient Prescription Drugs <i>(Mandatory generic)</i>	<ul style="list-style-type: none"> • Retail up to 34-day supply* *You may purchase up to a 90-day supply at a retail pharmacy by paying multiple copayments. • Mail service up to 90-day supply <i>(If You choose the brand when a generic is available, You pay Copayment plus 100% of the difference between the generic drug AC and the brand drug AC.)</i> 	Tier 1 - \$15 Tier 2 - \$20 Tier 3 - \$35 Tier 1 - \$18 Tier 2 - \$33 Tier 3 - \$63
Dental	Plan pays \$1,200 per member per calendar year, except for orthodontic services: <ul style="list-style-type: none"> • Diagnostic and preventive services • Primary services • Complex restorative • Orthodontic services (Plan pays \$1,200 per member per lifetime) 	\$0 20% AC* 50% AC 50% AC

	Covered Services	In-Network You Pay
Vision	<p>Once every 24 months:</p> <p>Routine eye exam</p> <p>Eyeglass frames (one pair)</p> <p>Eyeglass lenses (one pair)</p> <ul style="list-style-type: none"> • Single vision lenses • Bifocal lenses • Trifocal lenses OR • Contact lenses (any type) 	<p>\$25 per specialist Visit</p> <p>Remaining cost after Plan pay \$75</p> <p>Remaining cost after Plan pays \$50</p> <p>Remaining cost after Plan pay \$75</p> <p>Remaining cost after Plan pay \$100</p> <p>Remaining cost after Plan pay \$100</p>
Preventive Care and Immunizations	<ul style="list-style-type: none"> • Well baby care Visit <ul style="list-style-type: none"> ▪ Laboratory services ▪ Immunizations 	<p>\$15 per PCP Visit; \$25 per specialist Visit 10% AC \$0</p>
	<ul style="list-style-type: none"> • Annual routine gynecological Visit <ul style="list-style-type: none"> ▪ Annual Pap smear 	<p>\$15 per PCP Visit; \$25 per specialist Visit 10% AC</p>
	<ul style="list-style-type: none"> • Mammography screening and reading • Annual PSA test • Digital rectal examination 	<p>10% AC 10% AC \$15 per PCP Visit; \$25 per specialist Visit</p>
	<ul style="list-style-type: none"> • Covered preventive care tests and screenings, including office Visits, for members age 20 or older 	<p>\$0</p>
	<ul style="list-style-type: none"> • Covered immunizations and vaccinations for members age 6 and older 	<p>\$0</p>
Emergency Services for Life-Threatening Conditions	<ul style="list-style-type: none"> • Hospital emergency room • Physician care • Diagnostic x-rays, laboratory services, etc. 	<p>\$75 per Visit (waived if admitted)</p> <p>\$25 per specialist Visit 10% AC</p>
Mental Illness and Substance Abuse Services	<ul style="list-style-type: none"> • Outpatient Visit – authorized in advance of care; up to 50 Visits for non-biologically based mental illness • Outpatient Hospital • Inpatient and partial days of care; up to 30 days per Benefit Period; 90 day lifetime maximum for non-biologically based mental illness 	<p>\$25 per Visit</p> <p>\$75 per Visit</p> <p>\$200 per Confinement</p>

	Covered Services	In-Network You Pay
Annual Deductible and Lifetime Maximum	Applies to Major Medical Services only. Plan pays \$1,000,000 lifetime maximum per member.	Calendar year Deductible: <ul style="list-style-type: none"> • \$100 single • \$200 employee plus one • \$300 family Plus 20% AC
Annual Out-of-Pocket Expense Limit	Plan pays 100% AC once limit is met for covered services. (Certain expenses do not count toward this limit as defined in the Key Advantage Member Handbook on page 9.)	Calendar year limit: <ul style="list-style-type: none"> • \$1,000 single • \$2,000 employee plus one • \$1,000 per family member, up to \$3,000 total per family

*Allowable Charge (AC): See Definitions section.

Your Member Handbook may be printed at any time from the following Web sites:
www.thelocalchoice.state.va.us or www.anthem.com.

