Key Advantage

Notification of Changes to Your Member Handbook
Effective July 1, 2006 (and October 1, 2006 for certain school groups)

The Local Choice Health Benefits Program
Commonwealth of Virginia, Department of Human Resource Management

Keep this notification with your Key Advantage Member Handbook and Benefits Summary Insert, for a full and complete description of your coverage. You or your Benefits Administrator may view and print the handbook and the appropriate insert from The Local Choice Web site at www.thelocalchoice.state.virginia.gov or from Anthem Blue Cross and Blue Shield's site at www.anthem.com/cova.

1) You may now order additional ID cards by calling the ID Card Order Line toll-free at 866-587-6713.

Page 3 – Who to Contact for Assistance

2) The following language clarifies how services are covered for organ and tissue transplants when the donor is a covered person.

When only the donor is a covered person under the Plan, only the organ donation procedure itself, including services rendered at the time of the organ donation procedure, are covered services. Any services provided prior to the organ donation procedures are not covered, whether inpatient or outpatient, even if they are provided in anticipation of the organ donation or as preparation for the organ donation.

Page 5 – Item 9) Organ and Tissue Transplants, Transfusions

3) The final DHRM appeal process language is replaced as follows:

To further appeal a final coverage decision made by Your Plan through its internal appeal process, You must submit to the director of the Commonwealth of Virginia, Department of Human Resource Management (DHRM), in writing within 60 days of Your 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 DHRM with all information necessary to review the denial of Your claim. The Department 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 policy or eligibility issues will be reviewed by the director of DHRM. Claims denied because the treatment provided was considered not medically necessary will be referred to an independent medical review organization.

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For issues of medical necessity, the medical review organization will 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 medical review organization will:

- 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.

With other plan-related appeals to DHRM, if after review, the denial is upheld, that denial is final.

Beyond any final denial, You may appeal that determination as per the provisions of the Administrative Process Act within 30 days of the final DHRM determination.

What's Not Appealable at DHRM

The Department of Human Resource Management/The Local Choice (TLC) does not accept appeals for:

- specific coverage exclusions listed under "What is not covered" in the member handbook. However, denials of claims or coverage for services involving medical necessity (e.g. experimental or investigational procedures) can be appealed.
- matters in which the sole issue is disagreement with policies, rules, regulations, contract or law.
- claim amounts or service denials when the member's cost is less than $300.
- claim amounts above the allowable charge billed by a non-participating provider.

The decision of the plan administrator is final. If You are unsure whether a plan administrator's decision can be appealed, call the Office of Health Benefits, 804-371-8458.

You may download an appeals form at **www.thelocalchoice.virginia.gov.**

Page 8 – Final DHRM appeal process

4) The following information is added to primary and secondary coverage under your Coordination of Benefits provision.

- If a covered active employee or employee's dependent is also covered by Medicare, the coverage provided by the employer is primary (unless Medicare eligibility is due to End Stage Renal Disease).
- If a covered retiree, survivor or their covered dependent is eligible for Medicare, the Medicare-eligible participant is no longer eligible for coverage under this Plan (except during an End Stage Renal Disease coordination period). There is an exception for those in family membership who may maintain coverage under this Plan with Medicare as the primary coverage for any Medicare-eligible family member.

Page 10 – Primary Coverage and Secondary Coverage

5) The following replaces item 9) Treatment of Morbid Obesity information.

Your Plan covers treatment of morbid obesity through gastric bypass, or other methods recognized by the National Institutes of Health (NIH). According to the NIH guidelines, gastric bypass surgery is effective for the long-term reversal of morbid obesity for a patient who:

- weighs at least 100 pounds over or twice the ideal body weight for frame, age, height and gender as specified in the 1983 Metropolitan Life Insurance tables;

- has a body mass index equal to or greater than 35 kilograms per meter squared, with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes; or
- has a body mass index of 40 kilograms per meter squared, without such comorbidity.

As used above, body mass index equals weight in kilograms divided by height in meters squared.

Page 13 – Item 9) Treatment of Morbid Obesity

6) The following information replaces the section titled Prescription Drug Refills When Traveling.

If You are planning to travel on vacation or leaving home for an extended period, You may need one or more early refills of Your medication. Participating retail pharmacies and the *Medco by Mail* service may routinely provide one early refill (up to a 34-day or a 90-day supply, as appropriate) to accommodate travel. However, for extended travel, members should complete the Prescription Drug Refill Exception Request form available on the TLC Web site at **www.thelocalchoice.virginia.gov** or from Your Group Benefits Administrator. Send the completed form by fax or U.S. Mail to:

The Department of Human Resource Management (DHRM)
Office of Health Benefits
Attention: The Local Choice
101 North 14th Street, 13th Floor
Richmond, VA 23219
Fax: (804) 371-0231

The Local Choice will approve all valid requests and forward them to Medco Health Solutions, Inc. A member of Medco's customer service team will contact You to obtain specific medication information. Once You provide the medication information, a prior authorization will be entered for each medication requested and You will have 14 days to complete Your purchase.

Please note:

- the maximum supply You may purchase at one time is 12 months;
- You will not be allowed to purchase more refills than prescribed. For example, if Your one-year prescription expires six months from the date of Your request, You cannot purchase more than a six-month supply of medication;
- You will be charged the appropriate co-payments for refills requested on the form. For example, You will be charged for a 6-month supply of medication if You requested a 6-month supply on the form and later decided to purchase only a 3-month supply at the pharmacy;
- the Food and Drug Administration limits early refills on certain medications;
- allow at least two weeks for complete processing of Your request; and
- The Local Choice reserves the right to bill a participant for any months of medication remaining if employment terminates.

Page 31 – Prescription Drug Refills When Traveling

7) The following covered services under your dental diagnostic and preventive coverage are clarified as follows (changes denoted in bold italic).

- two sets of bitewing x-rays (two or more films) per Plan Year ***(vertical bitewings are considered a full mouth series and are allowed once every 36 months);***

- one complete full mouth x-ray series ***(vertical bitewings are considered a full mouth series)***, or a panorex every 36 months (the 36-month count starts the month in which You receive the x-ray series or panorex);
- occlusal night guards for demonstrated tooth wear due to bruxism and temporomandibular joint disorder (TMJ). ***Services are limited to once every five-year period.***

Page 33 – Dental Services, Diagnostic and preventive care

8) The following covered service under your basic dental care is added as follows:

- bone graft (only around natural teeth)

Page 33 – Dental Services, Basic dental care

9) The Better Prepared disease management program included under your Plan now covers metabolic syndrome (hypertension, hyperlipidemia, and obesity). This is in addition to disease management for asthma, diabetes, coronary artery disease, congestive heart failure, and chronic obstructive pulmonary disease (COPD).

Page 45 – Anthem Better Prepared

10) The following behavioral health services exclusion has been added.

- Inpatient rehabilitation for the sole treatment of a chemical dependency diagnosis.

Page 47 – Exclusions, Behavioral Health Services

11) The following dental services exclusions have been added.

- brush biopsies of the oral cavity
- biopsy of oral tissue

Page 48 – Exclusions, dental services

12) The nutritional counseling exclusion is modified as follows (change denoted in bold italics).

Your coverage does not include benefits for **nutritional counseling** and related services, except when provided as part of diabetes education, ***or in conjunction with covered surgery to treat Morbid Obesity.***

Page 51 – Exclusions, nutritional counseling

13) The Out-of-Pocket Expense limit is for a twelve month period from July 1 through June 30, *and October 1 through September 30 for groups who renew on October 1.* (Bold italic text denotes change.)

Page 71 – Definitions, 29) Out-of-Pocket Expense Limit

14) Your Plan covers Speech Therapy, which is treatment for the correction of a speech impairment which results from disease, surgery, injury, congenital anatomical anomaly, prior medical treatment. *Speech therapy to treat developmental delay is not covered, except as required by Section 2.2-2818 of the Code of Virginia for early intervention services.* (Bold italic text denotes change.)

Page 75 – Definitions, 50) Therapy Services, Speech Therapy

15) The Eligibility section on pages 76-79 of the handbook is replaced in its entirety by the following:

Active Employees

Full-time, part-time, and other classifications of employees may be eligible to participate. The local employer defines the categories of employees eligible to enroll when they complete the employer application that is forwarded to the Department of Human Resource Management. **For groups joining TLC after 6/30/2006, employees whether full time or part time, must work a minimum of 20 hours per week to be eligible for coverage. Groups currently participating in TLC will be allowed to continue their current practices.** If part-time employees are covered, all part-time employees in the same classification must be treated similarly.

Dependents

The following individuals are eligible for coverage under Your Plan:

- The employee's spouse
  - The marriage must be recognized as legal in the Commonwealth of Virginia.
- Children
  Under the health benefits program, the following eligible children may be covered to the end of the year in which they turn age 23 regardless of student status (age requirement is waived for adult incapacitated children), if the child lives at home or is away at school, is not married and receives over one-half of his or her support from the employee.
  - Natural and Adopted Children: In the case of natural or adopted children, living at home may mean living with the other parent if the employee is divorced.
  - If the biological parents are divorced, the support test is met if a natural or adopted child receives over one-half of their support from either parent or a combination of support from both parents. However, in order for the non-custodial parent to cover the child, the non-custodial parent must be entitled to claim the child as a dependent on his federal income tax return, or the custodial parent must sign a written declaration that he or she will not claim the child as a dependent on their federal income tax return.
  - Stepchildren: Unmarried stepchildren living with the employee in a parent-child relationship are eligible. However, stepchildren may not be covered as a dependent unless their principal place of residence is with the employee, and the child is a member of the employee's household. A stepchild must receive over one-half of his or her support from the employee.
  - Incapacitated Children: Adult children who are incapacitated due to a physical or mental health condition are eligible, as long as the child was covered by the Plan and the incapacitation existed prior to the termination of coverage due to the child attaining the limiting age. The employee must make written application, along with proof of incapacitation, prior to the child reaching the limiting age. Such extension of coverage must be approved by the Plan and is subject to periodic review. Should the Plan find that the child no longer meets the criteria for coverage as an incapacitated child, the child's coverage will be terminated at the end of the month following notification from the Plan to the enrollee.
  - Adult incapacitated children of new employees, may also be covered provided that:
    - The enrollment form is submitted within 31 days of hire;
    - The child has been covered continuously by group employer coverage since the disability first occurred; and
    - The disability commenced prior to the child attaining the limiting age of the Plan.
    - A letter from a physician explaining the nature of the incapacitation, date of onset and certifying that the dependent is not capable of self-support must accompany the enrollment form. This extension of coverage must be approved by the Plan in which the employee is enrolled.
  - Other Children: If a court has ordered the employee to assume sole permanent custody of a child, the child may be eligible. The principal place of residence must be with the employee, and the child must a member of the employee's household. Additionally, if the employee or spouse shares

custody with the minor child who is the parent of the "other child", then the other child may be covered. The other child, the parent of the other child, and the spouse who has custody must be living in the same household as the employee.

- When a child loses eligibility, coverage terminates at the end of the month in which the event that causes the loss of eligibility occurs.

Ineligible Persons

There are certain categories of persons who may not be covered as dependents under the program. These include:

- divorced spouses*
- parents
- grandparents
- aunts
- uncles
- dependent siblings**
- grandchildren**
- nieces**
- nephews**
- stepchildren unless both of these conditions are met:
  1) the stepchild lives with the member in a parent-child relationship, and
  2) the stepchild receives over one-half of his or her support from the employee
- a dependent child who is married
- children age 19 or older and not receiving over one-half of his or her support from the employee

*A court order to provide coverage for an ex-spouse does not make the ex-spouse eligible for coverage under this Plan.
**The Department of Human Resource Management determines eligibility.

NOTE: An employee's failure to remove ineligible persons from his or her health benefits membership may result in the retraction of claims and removal from the Plan for up to three years according to the regulations governing The Local Choice Health Benefits Program. The employee may not be allowed to reduce health benefits membership except within 31 days of the dependent's loss of eligibility, during Open Enrollment or with another consistent Qualifying Mid-Year Event.

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. **Medicare eligible retirees and Medicare eligible dependents of retirees may not remain in a Key Advantage Plan.**
- A Medicare supplement Plan may be available to retirees upon enrollment in Medicare Parts A and B and D. TLC supplement plans do not cover outpatient prescription drugs.
- Eligible dependents of a retiree 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; if alternate health insurance coverage is obtained; or when any applicable condition outlined in the policies and procedures of the Department of Human Resource Management causes termination.
  - 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 23 (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 Group Benefits Administrator for more information.

Enrollment and Changes

There are only certain times when You may enroll Yourself and eligible dependents in a health benefits plan, or change Your type of membership or plan.

When newly hired
Enroll within 31 days of the date of hire. Your health coverage is effective the first of the month after Your enrollment form is received. If You are hired on the first working day of the month and the form is received that day, Your coverage is effective the first of that month. A probationary period before the Effective Date may be applied if uniform for all employees.

Retirement
If the Local Employer offers Retiree coverage, retirees eligible for coverage in the Plan but not eligible for Medicare may elect to continue coverage and membership level under this Plan if they enroll in the retiree group within 31 days of their retirement date. Eligible retirees who did not participate in this Plan as an active employee prior to retirement may enroll in single coverage at the time of retirement if they do so within 31 days of their retirement date. Non-Medicare eligible retiree group Participants may make membership and/or Plan changes upon the occurrence of a qualifying mid-year event and Plan and/or membership changes at Open Enrollment. Retiree group Members may reduce their membership level at any time, and the Effective Date will be the first day of the month after the notification is received by their Group Benefits Administrator. However, retirees who cancel their coverage may not return to the program. **When a retiree becomes eligible for Medicare coverage, he or she must be terminated or changed to a Medicare Supplemental program.**

During Open Enrollment
Health benefits Open Enrollment usually occurs in the spring for active employees and retirees who are not eligible for Medicare (certain school groups may elect a fall Open Enrollment period). Open Enrollment is Your opportunity to make changes to Your Health Benefits Plan and/or type of membership. The benefits and premiums associated with Your Open Enrollment selections will be effective July 1 through June 30 of the following Plan Year (or October 1through September 30 for certain school groups).

Making changes outside of Open Enrollment
You may make membership changes during the Plan Year that are based on qualifying mid-year events. You must submit Your change within 31 days of the event. The change will be effective the first of the month after the date an election change is received. If notice is received the first day of the month, the change is effective that day. Other exceptions are birth, adoption, placement for adoption (changes take

effect the first of the month in which the event occurs) and termination of ineligible Members (changes are effective the last day of the month in which the Member loses eligibility).

Qualifying Mid-Year Events

Membership or plan changes outside of Open Enrollment are not permitted without a Qualifying Mid-Year Event. The following events permit a change outside Open Enrollment, but only if Your change is made on account of, and corresponds with, a qualifying mid-year event that affects Your own, Your spouse's or Your dependent's eligibility for coverage. You must also apply to make the change within 31 days of the event. If You have questions about these events, contact Your Group Benefits Administrator.

Change in Your employment status:
- begins/ends full-time employment
- begins/ends leave without pay or family medical leave
- ***changes from full-time to part-time or part-time to full-time***
- begins retirement

Change in Your marital status:
- marriage
- divorce
- death of a spouse

Change in Your number of eligible family members:
- birth or adoption (the Department of Human Resource Management must review all pre-adoptive placements to verify eligibility)
- death of a covered child
- covered child is no longer eligible for coverage under Your plan (exceeds plan's age limit, marries, becomes self-supporting, etc.)
- judgment, decree or order to add a child
- judgment, decree or order to remove a child
- permanent custody of a child

Changes affecting Your family member(s) employment
- spouse or covered child gains employer health plan eligibility (including switching from part-time to full-time employment)
- spouse or eligible child loses employer eligibility (including switching from full-time to part-time employment)
- spouse begins/ends leave without pay

Other changes affecting Your dependent(s)
- annual enrollment or significant change allowed under another employer's plan
- gains eligibility for Medicare or Medicaid
- loses eligibility for Medicare or Medicaid
- loses eligibility under another government sponsored plan

Changes due to special circumstances
- employee or dependent moves in or out of plan's service area
- HIPAA special enrollment due of loss of other coverage