Key Advantage
Member Handbook

Effective July 1, 2009 (and October 1, 2009 for certain school groups)

This Web version of the booklet and the most recent Benefits Summary insert for the plan in which you are enrolled (Key Advantage Expanded, 200, 300, or 500) reflects the most current description of benefits, limitations and exclusions under your plan as of *July 1, 2009 (and October 1, 2009 for certain school groups).*

The provisions in this booklet supersede all previous versions.

The Local Choice Health Benefits Program
Administered by the Department of Human Resource Management
Commonwealth of Virginia

T20585 (7/09)

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Key Advantage Health Benefits Plan

IMPORTANT NOTICE

Your Plan is administered by four Plan Administrators. Anthem Blue Cross and Blue Shield is the administrator for covered Medical Services; ValueOptions, Inc. for covered Behavioral Health Services and the Employee Assistance Program (EAP); Medco Health Solutions, Inc. for prescription drugs; and Delta Dental Plan of Virginia for routine dental services. This booklet describes covered Plan services administered by these companies under The Local Choice Health Benefits Program.

This booklet tells You what may be eligible for reimbursement under Your health benefits Plan. Refer to Your Benefits Summary insert to determine the specific amount You pay under the Plan for which You are enrolled. Throughout this booklet there are words which begin with capital letters. In most cases, these are defined terms. See the Definitions section for the meaning of these words.

Your employer provided health benefits Plan does not cover everything. There are specific exclusions for which the program will never pay. Even more important, payment for services is almost always conditional. That is, payment may be reduced or even denied for a service if You received the service without observing all the conditions and limits under which the service is covered. Finally, You almost always have to pay for part of the cost of treatment.

Your health benefits are contractual in nature. This means, in part, that what You or Your employer thinks is covered does not make it a covered service. Likewise, if You or Your employer thinks a service should be covered, that does not make it a covered service. The same is true even when the issue is life or death: a service is not covered simply because You, Your Physician, or Your employer believe You need the service, or because the service is the only remaining treatment which might (or might not) save Your life. This booklet, along with Your Benefits Summary insert, describes what services are eligible for reimbursement, the conditions under which the services are covered, the limits of coverage, and the amounts which may be payable under the specified conditions. You, and You alone, are responsible for knowing what is covered and the limits and conditions of coverage. Furthermore, the terms and conditions of Your coverage can be changed without Your consent, if proper notice is given to You. This booklet may be printed at any time from the following Web site: **www.thelocalchoice.virginia.gov**.

Your health benefits Plan pays part of the cost of health services needed to diagnose and treat illnesses and injuries. Services designed primarily to improve Your personal appearance are not eligible for reimbursement. Services which are not necessary for the diagnosis and treatment of illnesses or injuries are not eligible for reimbursement unless, in the sole judgment of the Plan Administrator, such services can reasonably be expected to avoid future costs to the Plan.

Still there is more You need to know. There are some rules which apply to all benefits. See General Rules Governing. Also, there are some services for which the Plan Administrator will never pay. See Exclusions section. Finally, we have included some rules governing the Plan. See Basic Plan Provisions section. Also refer to the Definitions section for an explanation of many of the terms used in this booklet. These sections are important because they will be used to determine exactly what this Plan covers.

WHO TO CONTACT FOR ASSISTANCE

The Local Choice Health Benefits Program

Web Address	**www.thelocalchoice.virginia.gov**
ID Card Order Line	866-587-6713

Medical Benefits - Anthem Blue Cross and Blue Shield

Member Services	800-552-2682 For the hearing impaired, please contact your state's relay service by dialing 711.
Web Address	**www.anthem.com/tlc**
Mailing Address	Anthem Blue Cross Blue Shield Member Services - Mail Drop VA13S141 P. O. Box 27401 Richmond, VA 23279

Behavioral Health and EAP Benefits - ValueOptions, Inc.

Member Services	866-725-0602
Web Address	**www.achievesolutions.net/tlc**
Mailing Address	ValueOptions, Inc. P. O. Box 12438 Research Triangle Park, NC 27709-2438

Outpatient Prescription Drug Benefits- Medco Health Solutions, Inc.

Member Services	800-355-8279
Web Address	**www.medco.com**
Mailing Address	Medco Health Solutions, Inc. 4121 Cox Road, Suite 118 Glen Allen, VA 23060

Dental Benefits - Delta Dental Plan of Virginia

Member Services	888-335-8296
Web Address	**www.deltadentalva.com**
Mailing Address	Delta Dental Plan of Virginia 4818 Starkey Road Roanoke, VA 23014

GENERAL RULES GOVERNING BENEFITS

1) **When a Charge Is Incurred**
   You incur the charge for a service on the day You receive the service.

2) **When Benefits Start**
   Benefits will not be provided for any charges You incur before Your Effective Date.

3) **Services Must Be Medically Necessary**
   In all cases, benefits will be denied if the Plan Administrator determines, in its sole discretion, that care is not Medically Necessary.

4) **When Benefits End**
   Benefits will not be provided for charges You incur after Your coverage ends. There are two exceptions. If You are an Inpatient the day Your coverage ends, Your Hospital coverage will continue until You are discharged to the extent that services were covered prior to the end of coverage. Also, Other Covered Services such as rental of medical equipment (durable) will be provided for a limited time for a condition for which You received covered services before Your coverage ended. The time will be the shorter of when You become covered under any other group coverage, or the end of the Plan Year Your coverage ends, or a period equal to the time You were enrolled under this Plan.

5) **Defining Services**
   When classifying a particular service, the Plan Administrator will use the most recent edition of a book published by the American Medical Association entitled Current Procedural Terminology (CPT). The Allowable Charge for a procedure will be based on the most inclusive code in Current Procedural Terminology. The Plan Administrator alone will determine the most inclusive code. No benefits will be provided for lesser included procedures or for procedures which are components of a more inclusive procedure.

6) **Payment to Network Providers**
   The Plan Administrator pays the Allowable Charge which remains after Your Copayment, Coinsurance, or Deductible to the Network Provider. These amounts may be collected at the time of service.

   When a Participant receives services from a Network Provider, the Plan Administrator will make payment for these services directly to the Provider. But, if the Participant has already paid the Provider and the Provider tells the Plan Administrator to do so, the Plan Administrator will pay the Member. A Provider who participates in one of the Plan Administrator's Networks will accept the Plan Administrator's allowance as payment in full for that service. Payment by the Plan Administrator will relieve the Plan Administrator and the Plan of any further liability for the service.

7) **Out-of-Network Medical or Behavioral Health Payments**
   When a Participant receives services from a Non-Network Medical or Behavioral Health Services Provider, the Plan Administrator may choose to make payment directly to the Member or, at the Plan Administrator's sole option, to any other person responsible for payment of the Provider's charge. Payment will be made only after the Plan Administrator has received an itemized bill and the medical information the Plan Administrator decides is necessary to process the claim. See Your Benefits Summary insert to determine what You

pay for Out-of-Network care. If the Plan's payment is made directly to the Member. The Member will be responsible for sending payment to the Provider. The Member also will be responsible for the difference between the Plan's allowance and the Provider's charge. Payment by the Plan Administrator will relieve it and the Plan of any further liability for the Non-Network Provider's services.

8) Alternative Benefits

The Plan may elect to offer benefits for an approved, alternative treatment plan for a patient who would otherwise require more expensive services, including, but not limited to, long term Inpatient care. The Plan will provide such alternative benefits at its sole option and only when and for so long as the Plan decides that the alternative services are Medically Necessary and cost effective. The total benefits paid for such services may not exceed the total which would otherwise be paid under this contract without alternative benefits. If the Plan elects to provide alternative benefits for a Participant in one instance, it will not be required to provide the same or similar benefits for any Participant in any other instance. Also, this will not be construed as a waiver of the State's right to administer this contract in the future in strict accordance with its express terms.

9) Organ and Tissue Transplants, Transfusions

Your Plan covers some but not all organ and tissue transplants. Medical necessity review is required to determine if a specific organ or tissue transplant service will be covered. When a human organ or tissue transplant is provided from a living donor to a covered person, both the recipient and the donor may receive the benefits of the health Plan. However, benefits for these services are limited only to those not available to the donor from any other source, including, but not limited to, other insurance coverage or any government program.

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.

Covered services for the identification of a suitable donor to a covered person for an allogeneic bone marrow transplant will include a computer search of established bone marrow registries and laboratory testing necessary to establish compatibility of potential donors. Donors may be from the patient's immediate family or have been identified through the computer search. These services must be ordered by a doctor qualified to provide allogeneic transplants.

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.

10) Complaint and Appeal Process

You have access to both a complaint process and an appeal process. Should You have a problem or question about Your Plan, the appropriate Plan Administrator's Member

Services Department will assist You. Most problems and questions can be handled in this manner. For medical, Your Plan Administrator is Anthem. For Behavioral Health Services and EAP benefits, Your Plan Administrator is ValueOptions. Delta Dental is the Plan Administrator for routine dental benefits. Medco Health is the Plan Administrator for Your prescription drug benefits. You may also file a written complaint or appeal. Complaints typically involve issues such as dissatisfaction about Your Plan's services, quality of care, the choice of and accessibility to Your Plan's Providers and network adequacy. Appeals typically involve a request to reverse a previous decision made by Your 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 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 medical, behavioral health, dental or prescription drug coverage may be filed to the following addresses:

Anthem Blue Cross and Blue Shield (for medical, optional vision and hearing)
Attn: Member Services
P.O. Box 27401
Richmond, VA 23279

Delta Dental Plan of Virginia (for dental)
4818 Starkey Road, S. W.
Roanoke, VA 24014

Medco Health Solutions, Inc. (for prescription drug)
Call 800-355-8279

ValueOptions, Inc. (for behavioral health)
Attn: Complaints and Grievances Department
P. O. Box 12438
Research Triangle Park, NC 27709-2438

Appeal process

Your Plan is committed to providing a full and fair process for resolving disputes and responding to requests to reconsider a coverage decision You find unacceptable. There are two types of appeals:

- Plan Administrator appeals are requests to reconsider coverage decisions of pre-service or post-service claims. A separate expedited Emergency appeals procedure is available to provide resolution within one business day of the receipt of a complaint or appeal concerning situations requiring immediate medical care. Situations in which expedited appeals are available include those involving prescriptions to alleviate cancer pain. All appeals to the Plan Administrator must be exhausted before an appeal can be made to the Department of Human Resource Management (DHRM).

- after Plan Administrator appeals are exhausted, You may request of DHRM an appeal process that includes an impartial clinical review by an independent, external reviewer of the final coverage decision made by the Plan Administrator. Additionally, other Plan related issues may be appealed to DHRM as well. More information about this appeal may be found in the Final DHRM appeal process section.

How to appeal a coverage decision

To appeal a coverage decision, please send a written explanation to the appropriate Plan Administrator's address (see addresses in this section) of why You feel the coverage decision was incorrect. (Alternatively, Anthem will accept a verbal request for appeal by calling a Member Services representative.) You may provide any comments, documents or information that You feel the Plan Administrator 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.

Addresses for appeals

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

Medco Health Solutions, Inc.
Attn: Coverage Appeals
8111 Royal Ridge Parkway
Irving, TX 75063

Delta Dental Plan of Virginia
Attn: Appeals
4818 Starkey Road, S.W.
Roanoke, VA 24014

ValueOptions, Inc.
Attn: Appeals Coordinator
P.O. Box 12438
Research Triangle Park, NC 27709-2438

How the Plan Administrator will handle Your appeal

In reviewing Your appeal, the Plan Administrator 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 new 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 a practitioner who holds a non-restricted license in the Commonwealth of

Virginia or under comparable licensing law in the same or similar specialty as one who typically manages the medical condition, procedure or treatment under review. Any other decision that involves the review of medical information will be made by appropriate clinical staff.

The Plan Administrator will resolve and respond in writing to Your appeal within the following time frames:

- for pre-service claims, the Plan Administrator will respond in writing within 30 days after receipt of the request to appeal;
- for post-service claims, the Plan Administrator will respond in writing within 60 days after receipt of the request to appeal; or
- for expedited appeals, the Plan Administrator will respond orally within one working day after receipt from the Member or treating Provider of the request to appeal, and will then provide written confirmation of its decision to the Member and treating Provider within 24 hours thereafter.

When the review of Your appeal by the Plan Administrator 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.

Final DHRM appeal process

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.

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**.

11) Coordination of Benefits

Coordination of benefits (COB) rules apply when You or Members of Your family have additional health care coverage through other group health Plans, including:

- group insurance Plans, including other Blue Cross and Blue Shield Plans or HMO Plans;
- labor management trustee Plans, union welfare Plans, employer welfare Plans, employer organization Plans, or employee benefit organization Plans; and
- coverage under any tax-supported or government program to the extent permitted by law.

Primary Coverage and Secondary Coverage
When a covered person is also enrolled in another group health Plan, one coverage will be primary and one will be secondary. The decision of which coverage will be primary or secondary is made using the order of benefit determination rules. Highlights of these rules are described below:

- if the other coverage does not have COB rules substantially similar to this health Plan's, the other coverage will be primary.
- if a covered person is enrolled as the named insured under one coverage and as a dependent under another, generally the one that covers him or her as the named insured will be primary.
- if a covered person is the named insured under both coverages, generally the one that covers him or her for the longer period of time will be primary.
- if the covered person is enrolled as a dependent child under both coverages (for example, when both parents cover their child), typically the coverage of the parent whose birthday falls earliest in the Plan Year will be the primary.
- special rules apply when a covered person is enrolled as a dependent child under two coverages and the child's parents are separated or divorced. Generally, the coverage of the parent or step-parent with custody will be primary. However, if there is a court order that requires one parent to provide for medical expenses for the child, that parent's coverage will be primary. If there is a court order that states that the parents share joint custody without designating that one of the parents is responsible for medical expenses, the coverage of the parent whose birthday falls earliest in the Plan Year will be primary.

When Your Plan is the Primary Coverage, it pays first. When Your Plan is the Secondary Coverage, it pays second as follows:

- we calculate the amount Your Plan would have paid if it had been the Primary Coverage, then coordinate this amount with the primary Plan's payment. The combination of the two will not exceed the amount Your Plan would have paid it if had been Your Primary Coverage.
- some Plans provide services rather than making a payment (i.e., a group model HMO). When such a Plan is the Primary Coverage, Your Plan will assign a reasonable cash value for the services and that will be considered the primary Plan's payment. Your Plan will then coordinate with the primary Plan based on that value.
- in no event will Your Plan pay more in benefits as Secondary Coverage than it would have paid as Primary Coverage.
- 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).
- 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).

12) Overpayment of benefits

If Your Plan overpays benefits because of COB, Your Plan has the right to recover the excess from:

- any person to, or for whom such payments were made;
- any insurance company; or
- any other organization.

You will be required to cooperate with Your Plan to secure this right.

13) Out-of-Pocket Expense Limit

When You incur the Out-of-Pocket Expense Limit for covered medical and Behavioral Health Services in a Plan Year, the Plan Administrator will pay the out-of-pocket expenses for covered services You receive during the remainder of that Plan Year. All Participants in the same immediate family must satisfy no more than a total of in the family Out-of-Pocket Expense Limit in a Plan Year. See Your Benefits Summary insert for the Out-of-Pocket Expense Limit(s) that applies to the Plan in which You are enrolled.

There is no Out-of-Pocket Expense Limit for covered dental and outpatient prescription drug services.

The following do not apply to the Medical Services and Behavioral Health Services Out-of-Pocket Expense Limit and will not be paid when the Out-of-Pocket Expense Limit has been reached:

- Copayments for covered Medical and Behavioral Health Services;
- any amounts in excess of the Allowable Charge for a covered service or any amounts in excess of fixed dollar benefit limits listed in any section; or
- expenses for services or supplies not covered by the Plan

14) Notice from the Plan Administrator to You

A notice sent to You by the Plan Administrator is considered "given" when delivered to The Local Choice Group or Your Benefits Administrator at the address listed in the Plan Administrator's records. If the Plan Administrator must contact You directly, a notice sent to You by the Plan Administrator is considered "given" when mailed to the Member at the Member's address listed in the Plan Administrator's records. Be sure the Plan Administrator has the Member's current home address.

15) Notice from You to the Plan Administrator

Notice by You or Your Benefits Administrator is considered "given" when delivered to the Plan Administrator. The Plan Administrator will not be able to provide assistance unless the Member's name and identification number are in the notice.

INSTITUTIONAL SERVICES

Medical Services administered by Anthem Blue Cross and Blue Shield; Behavioral Health Services administered by ValueOptions, Inc.

HOSPITAL SERVICES

The charges made by a Hospital for use of its facilities and services are eligible for reimbursement under many circumstances.

Services Which Are Eligible for Reimbursement

1) Bed and board in a Semi-Private Room, including general nursing services and special diets. A bed in an intensive care unit is eligible for reimbursement for critically ill patients. Your Plan covers the charge for a private room if You need a private room because You have a highly contagious condition; You are at greater risk of contracting an infectious disease because of Your medical condition; or if the Hospital only has private rooms. Otherwise, You have coverage for a Semi-Private Room. If You choose to occupy a private room, You will be responsible for paying the daily differences between the semi-private and private room rates in addition to any Copayment or Coinsurance that may apply.

2) Customary ancillary services for Inpatient Stays, including operating rooms, medications, oxygen and oxygen tents, dressings and casts, anesthesia, transfusions, Diagnostic Tests and Therapy Services, Emergency room services leading directly to admission or which are rendered to a patient who dies before being admitted, ambulance services for transportation between local Hospitals when Medically Necessary, and routine nursery care of a newborn as part of a mother's covered Maternity Service.

3) Partial Hospitalization for Behavioral Health Services. These services are available on the same basis as Inpatient services.

4) Outpatient Hospital services including pre-admission testing and other Diagnostic Tests, Therapy Services, Shots, Surgical Services, Inpatient ancillary services when unavailable in an Inpatient facility, mammography, Partial Hospitalization for Behavioral Health Services, and routine colonoscopy screening.

5) One routine screening mammogram per Plan Year for Participants age 35 and older

6) One routine gynecological examination (breast exam, pelvic exam, and pap smear) per Plan Year

7) One routine prostate specific antigen (PSA) test and digital rectal examination per Plan Year for Members age 40 and over in accordance with American Cancer Society guidelines

8) One colorectal cancer screening per Plan Year for Members age 40 and over as outlined:
   - one fecal occult blood test; and
   - one flexible sigmoidoscopy, or colonoscopy, or double contrast barium enema.

9) 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.

10) Your health plan covers some services (such as abdominoplasties, panniculectomies, and lipectomies) to correct deformity after a previous theapeutic process involving gastric bypass surgery, other bariatric surgery procedures, or other methods of weight loss. In order to be covered, a service must be medically necessary. Before rendering any of these services, Your Provider should contact the Plan Administrator and request a medical necessity review.

Conditions for Reimbursement

1) Inpatient and Outpatient Hospital services must be:

   - prescribed by a Provider licensed to do so;
   - furnished and billed by a Hospital; and
   - Medically Necessary.

2) In addition to any Copayments, Coinsurance and Deductible that apply as outlined in Your Benefits Summary insert, You may be financially responsible for the entire Hospital bill if, after Your admission to the Hospital, the Plan Administrator finds that the Inpatient Stay was not Medically Necessary. In order to avoid this, You must comply with the following Hospital admission review procedure:

   a. You, Your Physician, the admitting Physician, a family member, or a friend must contact the appropriate Plan Administrator by telephone or by letter prior to a non-emergency Inpatient service and furnish the following information:

      - Physician's name, address, and telephone number;
      - name and address of the Hospital to which Your admission is planned;
      - Your name and Member identification number;
      - anticipated admission date and length of Stay; and
      - medical justification for Inpatient treatment.

   After an Emergency admission, You, Your Physician, the admitting Physician, a family member, or a friend must contact the appropriate Plan Administrator within 48 hours or, if later, the next business day and furnish the above information.

   b. You, Your Physician, the admitting Physician, a family member, or a friend must receive a response from the appropriate Plan Administrator, either approval or disapproval, prior to the rendering of the non-emergency Inpatient service.

The Plan Administrator will respond to a Hospital admission review request within 24 hours after its receipt. The Plan Administrator may request additional information in order to determine whether to approve or disapprove benefits for an Inpatient service. In this case, the Plan Administrator will respond with an approval or disapproval within 24 hours after the necessary information is supplied.

If, as a part of the Hospital admission review program, the Plan Administrator determines that a contemplated Inpatient service is not Medically Necessary and the Participant elects to proceed with the Inpatient service despite this determination, the Plan Administrator will deny this service as not Medically Necessary unless additional information is provided indicating a contrary result is warranted. You are financially responsible for Hospital services which are not Medically Necessary.

c. The Plan Administrator may not require the Hospital admission review procedure to be followed for admissions that arise over the weekend.

3) Mammograms are covered provided that:

a. The mammogram is:

- ordered by a licensed Provider;
- performed by a registered technologist;
- interpreted by a qualified radiologist;
- performed under the direction of a person licensed to practice medicine and surgery, and certified by the American Board of Radiology or an equivalent examining body; and
- a copy of the mammogram report is delivered to the Provider who ordered the mammogram.

b. The equipment used to perform the mammogram meets the standards set forth by the Virginia Department of Health in its radiation protection regulations.

c. The mammography film is retained by the radiology facility performing the examination in accordance with the American College of Radiology guidelines or State law.

4) Members are encouraged to have all Behavioral Health Services pre-authorized, unless the rules for emergencies apply. Authorization is required within 48 hours of an Emergency.

5) A Health Service Review (pre-service review) is required for elective diagnostic imaging services including:

- cardiac nuclear studies (such as cardiac stress tests)
- CT scans;
- MRI, MRA; and
- PET, SPECT scans.

This list of services is only a sampling and may change, so always check with Your Physician or Anthem Member Services for the most current and complete list.

6) The cost of blood, blood plasma, blood derivatives, or professional donor fees are covered as Other Covered Services.

Reimbursement

Refer to the Benefits Summary insert for the Plan in which You are enrolled.

SKILLED NURSING FACILITY SERVICES

Administered by Anthem Blue Cross and Blue Shield

Services Which Are Eligible for Reimbursement

The Plan Administrator will cover Your Semi-Private Room in a Network Skilled Nursing Facility. The room charge includes Your meals, any special diets, and general nursing services. You are also entitled to receive the same types of ancillary services which are available to a Hospital Inpatient.

Your health plan will cover the private room charge if You need a private room because You have a highly contagious condition or are at greater risk of contracting an infectious disease because of Your medical condition. Otherwise, Your inpatient benefits would cover the skilled nursing facility's charges for a semi-private room. If You choose to occupy a private room, You will be responsible for paying the daily differences between the semi-private and private room rates in addition to Your copayment and coinsurance (if any).

Conditions for Reimbursement

1) Care which is necessary for a person who does not have a treatable medical illness or injury is not covered. For example, a person is not eligible for covered care in a Skilled Nursing Facility simply because the person is unable to care for himself (that is, the person cannot perform several activities of daily living, such as bathing or feeding).

2) Skilled Nursing Facility Services must also be:

   - Medically Skilled Services;
   - prescribed by Your Provider and listed in the Plan of Treatment;
   - furnished and billed for by the Skilled Nursing Facility; and
   - Medically Necessary.

3) You may be financially responsible for the entire Hospital bill if, after Your admission to the Hospital, the Plan Administrator finds that the Inpatient Stay was not Medically Necessary. In order to avoid this, You must comply with the following procedure.

   a. You, Your Physician, the admitting Physician, family member, or a friend must contact the Plan Administrator by telephone or by letter prior to a non-emergency Inpatient service and furnish the following information:

      - Physician's name, address, and telephone number;
      - name and address of the Hospital to which Your admission is planned;
      - Your name and Member identification number;
      - anticipated admission date and length of Stay; and
      - medical justification for Inpatient treatment.

   b. You or Your Physician must receive a response from the Plan Administrator, either approval or disapproval, prior to the rendering of the non-emergency Inpatient service.

The Plan Administrator will respond to a Hospital admission review request within 24 hours after its receipt. The Plan Administrator may request additional information in order to determine whether to approve or disapprove benefits for an Inpatient service.

In this case, the Plan Administrator will respond with an approval or disapproval within 24 hours after the necessary information is supplied.

(i) If, as a part of the Hospital admission review procedure the Plan Administrator determines that a contemplated Inpatient service is not Medically Necessary and the Participant elects to proceed with the Inpatient service despite this determination, the Plan Administrator will deny this service as not Medically Necessary unless additional information is provided indicating a contrary result is warranted. You are financially responsible for Hospital services which are not Medically Necessary.

c. The Plan Administrator may not require the Hospital admission review procedure to be followed for admissions that arise over the weekend.

Special Limits

Days of Inpatient care	180 days per Stay

Reimbursement

Refer to the Benefits Summary insert for the Plan in which You are enrolled.

BEHAVIORAL HEALTH SERVICES

Administered by ValueOptions, Inc.

Eligible Behavioral Health Services are covered if Medically Necessary. Services for alcohol and substance abuse may be reimbursable when rendered in an Outpatient setting.

Detoxification and Partial Hospitalization may be reimbursable when rendered in an Inpatient setting. Residential treatment is not a covered benefit.

You and any "household" members also have coverage for up to four Visits per incident under Your Employee Assistance Program (EAP).

Conditions for Reimbursement

Members are encouraged to have all Behavioral Health Services pre-authorized by calling ValueOptions toll-free at 1-866-725-0602 before receiving care, or within 48 hours of an Emergency admission.

Reimbursement

Refer to the Benefits Summary insert for the Plan in which You are enrolled.

HOME HEALTH CARE SERVICES

Administered by Anthem Blue Cross and Blue Shield

Services Which Are Eligible for Reimbursement

Home health care services include:

- professional Medical and Surgical services.
- periodic nursing care furnished by a Licensed Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) under the supervision of an R.N.
- Therapy Services.
- medical social services provided by a licensed clinical social worker or social services assistant under the guidance of a licensed clinical social worker.
- services by a home health aide for personal care provided under the supervision of an R.N.
- nutritional guidance, but limited to individual consultation by an R.N. or qualified dietician.
- Diagnostic Tests, non-covered Therapy Services, and similar services which would be covered if You were an Inpatient in a Hospital. These services are also covered when received in Your Provider's office or the Outpatient department of a Hospital, but the services must be arranged through the Network home health care agency.
- Ambulance services if prearranged by Your Physician and authorized by the Plan Administrator if, because of Your medical condition, You cannot ride safely in a car when You go to Your Provider's office or to the Outpatient department of the Hospital. Ambulance services will be covered if Your condition suddenly becomes worse and You must go to a local Hospital's Emergency room.
- supplies normally used in a Hospital for an Inpatient, but these supplies must be dispensed by the Network home health care agency.
- drugs of the type You would have received in the Hospital. These drugs must be ordered by Your Provider. They must also be dispensed by the Network home health care agency.

Conditions for Reimbursement

1) Home health care services must be provided in Your home or the Outpatient department of a Hospital. Unless otherwise noted, they must be Medically Skilled Services. Home health care services must also be:

    - prescribed by a Provider licensed to do so;
    - listed in Your Plan of Treatment filed with the Plan Administrator;
    - furnished and billed by a Network home health care agency;
    - services the Plan Administrator approves for payment before services are rendered; and
    - Medically Necessary.

2) You must be homebound for medical reasons. You must be physically unable to obtain medical care as an Outpatient. You will still be considered homebound for medical reasons if You must go to the Outpatient department of the Hospital because the services You need cannot be furnished in Your home.

3) You must be under the active care of a Provider to be eligible for home health care services. Your Provider must certify to the Plan Administrator that You would be in a Hospital as an Inpatient if home health care services were not available.

4) Home health care services will be provided after Your discharge from a Hospital as an Inpatient only when:

- the Plan Administrator has received and approved Your Plan of Treatment in advance;
- Your Provider has certified in writing that You would have to remain in the Hospital as an Inpatient if home health care services were not available; and
- home health care services begin within 3 days after Your discharge. The Plan Administrator may waive the 3 day time limit in unusual situations, such as discharge over a weekend. However, waiver is at the Plan Administrator's sole option.

5 If You are not first confined in a Hospital, home health care services will be provided only when:

- the Plan Administrator has received and approved Your Plan of Treatment in advance; and
- Your Provider has certified in writing that You would have to be admitted to a Hospital as an Inpatient if home health care services were not available.

6) Services must follow Your Plan of Treatment. Your Plan of Treatment must be included in Your medical record. Your medical record must be reviewed by Your Provider at regular intervals. A copy of Your Plan of Treatment must be filed with the Plan Administrator before Home health care services can begin. Any changes to Your Plan of Treatment must be approved for payment in advance by the Plan Administrator.

7) Services must be furnished by trained health care workers employed by the Network home health care agency. A Network home health care agency may make arrangements with another health care organization to provide You with a home health care service, but the Plan Administrator must approve any such arrangement with another health care organization in writing in advance.

8) The following rules apply only to Visits for home health care services:

- when a health care worker comes to Your home more than once a day to provide Home health care services, each Visit will be counted as a separate Visit;
- when two or more health care workers come to Your home at the same time to provide a single service, the joint Visit will be counted as one Visit;
- when two or more health care workers come to Your home to provide different types of home health care services, the Visit of each health care worker will be counted as a separate Visit; and
- when special medical equipment is needed that cannot be brought into Your home, each time You leave home to use the equipment will be counted as a separate Visit.

9) Approval of a Plan of Treatment, or any part of a Plan of Treatment, or any arrangement with another health care organization means only that the Plan Administrator will later consider these services for payment. The Plan Administrator's approval is neither an endorsement of the quality of the service nor a waiver of any term or condition of this contract.

10) Disapproval of a Plan of Treatment, or any part of a Plan of Treatment, or any arrangement with another health care organization means only that the Plan Administrator has determined in advance the services are not covered under this section. Some private duty nursing services, medical supplies, and medical equipment (durable) may be covered as separately listed Other Covered Services. Please see the Other Covered Services section.

    You may still elect to receive any other services disapproved by the Plan Administrator, but these will be at Your own expense.

11) Therapy Services must be rendered by a therapist qualified to do so.

12) Your need for personal care must be determined by the R.N. working for the Network home health care agency. The R.N. must assign duties to the home health aide. Personal care may include non Medically Skilled Services. The words "personal care" mean:

- helping You walk;
- helping You take a bath;
- helping You dress;
- giving You medicine; and
- teaching You self help skills.

Special Limits

Visit maximum 90 Visits per Plan Year

Payment will not be made for:

- homemaker or housekeeping services;
- housing, food, home delivered meals, or "Meals on Wheels";
- services not listed in Your attending Provider's Plan of Treatment, except for ambulance services to a Hospital Emergency room;
- counselor's services;
- services which are or are related to diversional, recreational, or social activities; or
- prosthetic devices, appliances, and orthopedic braces.

Reimbursement

Refer to the Benefits Summary insert for the Plan in which You are enrolled.

PROFESSIONAL SERVICES

MEDICAL, SURGICAL, AND BEHAVIORAL HEALTH SERVICES

Medical Services administered by Anthem Blue Cross and Blue Shield; Behavioral Health Services administered by ValueOptions, Inc.

This section explains which Medical, Surgical, and Behavioral Health Services from health professionals may be eligible for reimbursement. In general, the professional services of authorized Providers are eligible for reimbursement if they are Medically Necessary and rendered within the scope of the Provider's license.

Services Which Are Eligible for Reimbursement

1) Inpatient Medical, Surgical, and Behavioral Health Services. These services are specifically included:

   - reconstructive surgery to restore a body function, correct congenital or developmental deformity which causes functional impairment, or relieve pain
   - operative procedures for sterilization or to reverse a sterile condition
   - multiple surgeries
   - assistant surgeon's services
   - Maternity Services rendered during an Inpatient Stay:
     - routine delivery services (Cesarean birth is a Surgical Service)
     - services for complications of pregnancy
     - services for miscarriage or other interruptions of pregnancy
     - services for the care of a newborn child if the child is a Participant at the time the services are rendered
   - Anesthesia Services rendered by a second Physician
   - Medical and Behavioral Health Visits by a Provider, including:
     - intensive Medical Services (when Your medical condition requires a Provider's constant attendance and treatment for a prolonged period of time)
     - concurrent care (treatment You receive from a Provider other than the operating surgeon for a medical condition separate from the condition for which You required surgery)
     - consultative services from a Provider other than the attending Provider
   - Behavioral Health Services, including services for the treatment of alcohol or substance abuse

2) Outpatient Medical, Surgical, and Behavioral Health Services, including:
   - Surgical Services
   - Maternity Services, including Visits to a Provider for routine pre- and postnatal care, and delivery of a newborn at home by a Provider
   - Anesthesia Services
   - Medical Services to diagnose or treat Your illness or injury
   - Diagnostic Tests
   - Therapy Services
   - Shots

- outpatient self-management training and education performed in person; including medical nutrition therapy, when provided by a certified, licensed, or registered health care professional. Diabetic education is covered at no cost to You.
- Behavioral Health Services, including services for the treatment of alcohol and substance abuse; and Employee Assistance Program (EAP) services, including confidential assessment and short-term problem solving available to all Participants and eligible "household" members.
- Well Child, including coverage for routine care, screenings, checkups, and immunizations for Your child through age 6. These services are based on the recommendations of the American Academy of Pediatrics, and include:
  - complete physical examinations, developmental assessment and guidance;
  - immunizations such as diphtheria, tetanus, pertussis (DTP), polio, measles, mumps, rubella (MMR), hemophilus vaccine (HIB), hepatitis B, varicella virus (chicken pox) vaccine, pneumococcal conjugate vaccine, influenza, and other immunizations as may be prescribed by the Commissioner of Health; and
  - certain laboratory and screening tests, including hearing and vision tests required for a preschool physical exam.

  The American Academy of Pediatrics recommends the following schedule for well child Visits:

  - 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
  - 3 years
  - 4 years
  - 5 years
  - 6 years

- one routine screening mammogram per Plan Year for Participants age 35 and older
- one routine gynecological examination (breast exam, pelvic exam, and Pap smear) per Plan Year
- one routine prostate specific antigen (PSA) test and digital rectal examination per Plan Year for Members age 40 and over in accordance with American Cancer Society guidelines
- one colorectal cancer screening per Plan Year for Members age 40 and over as outlined:
  - one fecal occult blood test, and
  - one flexible sigmoidoscopy, or colonoscopy, or double contrast barium enema.
  If in the course of a colonoscopy screening a polyp or other abnormality is identified, biopsied and/or removed, the service will be considered diagnostic and/or surgical rather than screening.
- a Medical or Surgical Service if performed by a Provider's Employee who is licensed to perform the service

Conditions for Reimbursement

1) Medical, Surgical, and Behavioral Health Services must be:

- Medically Skilled Services;
- billed for by a Provider in private practice;
- services which the Provider is licensed to render; and
- Medically Necessary.

2) When more than one Surgical Service is performed during a single operation, Your Allowable Charge for the combined services will be calculated as follows:

   - the Allowable Charge for the most costly Surgical Service performed; plus
   - 50% of what Your Allowable Charge would have been for the additional Surgical Services if these services had been performed alone.

3) Assistant surgeon's services are covered if the operating surgeon explains to the Plan Administrator, upon request, why this Surgical Service requires the skills of two surgeons. When two or more surgeons provide a Surgical Service which could reasonably have been performed by one surgeon, the Allowable Charge for this Surgical Service will not exceed the Allowable Charge available to one surgeon.

4) Inpatient consultative services are covered provided that the services are requested by Your attending Provider. The Provider rendering the consultative services must examine You and must enter a signed consultation note in Your medical record.

5) Mammograms are covered provided that:

   a. The mammogram is:

      - ordered by a Provider;
      - performed by a registered technologist;
      - interpreted by a qualified radiologist;
      - performed under the direction of a person licensed to practice medicine and surgery, and certified by the American Board of Radiology or an equivalent examining body; and
      - a copy of the mammogram report is delivered to the Provider who ordered the mammogram.

   b. The equipment used to perform the mammogram meets the standards set forth by the Virginia Department of Health in its radiation protection regulations.

   c. The mammography film is retained by the radiology facility performing the examination in accordance with the American College of Radiology guidelines or State law.

6) If You are admitted to the Hospital for an Emergency, You, Your Physician, the admitting Physician, a family member, or a friend must contact the Plan Administrator within 48 hours or, if later, the next business day.

Special Limits

1) Inpatient professional services in a Skilled Nursing Facility are limited to 180 days per Stay.

2) Employee Assistance Program provides up to four Visits per incident per year for Participants and eligible “household” members.

3) If a Visit is part of a home health care services program, it will reduce by one the maximum number of Visits available for home health care services.

4) Chemotherapy by oral means is excluded under Medical Services.

Reimbursement

1) Refer to the Benefits Summary insert for the Plan in which You are enrolled.

2) Separate benefits will not be provided for routine pre- and post-operative care. The Plan Administrator takes these services into account when determining its Allowable Charge for a Surgical Service.

3) When the same Physician performs both the Surgical or Maternity Service and the Anesthesia Service, the Allowable Charge for the Anesthesia Service will be 50% of what the Allowable Charge would have been if a second Physician had performed the Anesthesia Service.

PREVENTIVE CARE

Administered by Anthem Blue Cross and Blue Shield

Services Which Are Eligible for Reimbursement

The following services (one of each per Plan Year) are eligible for reimbursement.

1) Routine gynecological examination

2) Routine pap test

3) Routine mammography screening for Participants age 35 and older

4) Prostate exam (digital rectal exam) for Participants age 40 and older

5) Prostate specific antigen test for Participants age 40 and older

6) Colorectal cancer screening for Participants age 40 and older, including:
   - one fecal occult blood test; and
   - one flexible sigmoidoscopy, or colonoscopy or double contrast barium enema.

Conditions for Reimbursement

Preventive care services must be:

- billed for by a Provider in private practice; and
- services which the Provider is licensed to render.

Reimbursement

Refer to the Benefits Summary insert for the Plan in which You are enrolled.

ROUTINE WELLNESS SERVICES

Administered by Anthem Blue Cross and Blue Shield

Services Which Are Eligible for Reimbursement

The following services are eligible for reimbursement for Participants age 7 and older.

1) One check up Visit per Plan Year

2) Routine wellness immunizations, laboratory and x-ray services

Conditions for Reimbursement

Immunizations must be:

- billed for by a Provider in private practice; and
- services which the Provider is licensed to render.

Special Limits

This benefit has a limit. Refer to the Benefits Summary insert for the Plan in which You are enrolled.

Reimbursement

Refer to the Benefits Summary insert for the Plan in which You are enrolled.

SPINAL MANIPULATION AND OTHER MANUAL MEDICAL INTERVENTION SERVICES

Administered by Anthem Blue Cross and Blue Shield

Services Which Are Eligible for Reimbursement

Spinal manipulations and other manual medical interventions and associated evaluation and management services, including manipulation of the spine and other joints, application of manual traction and soft tissue manipulations are eligible for reimbursement.

Conditions for Reimbursement

Services must be:

- performed by a licensed chiropractor or licensed medical Provider;
- billed for by a chiropractor in private practice or a Provider;
- those which the Provider is licensed to render; and
- Medically Necessary.

Special Limits

This benefit has a limit. Refer to the Benefits Summary insert for the Plan in which You are enrolled.

Reimbursement

Refer to the Benefits Summary insert for the Plan in which You are enrolled.

HOSPICE CARE SERVICES

Administered by Anthem Blue Cross and Blue Shield

Services Which Are Eligible for Reimbursement

1) Hospice care services are available if You are diagnosed with a terminal illness with a life expectancy of six months or fewer.

2) Hospice care services include a program of home and Inpatient care provided directly by or under the direction of a licensed hospice.

3) Hospice care programs include palliative and supportive Physician, psychological, psychosocial, and other health services to individuals utilizing a medically directed interdisciplinary team.

Conditions for Reimbursement

Hospice care services must be:

- prescribed by a Provider licensed to do so;
- furnished and billed by a licensed hospice; and
- Medically Necessary.

Reimbursement

Refer to the Benefits Summary insert for the Plan in which You are enrolled.

VISION SERVICES

(Key Advantage Expanded and Key Advantage 200 Plans Only)

Administered by Anthem Blue Cross and Blue Shield

Services Which Are Eligible for Reimbursement

1) Routine vision examinations

2) Frames and the following prescription lenses to correct refraction error:

- single lenses, or
- bifocal lenses, or
- trifocal lenses, or
- contact lenses (hard, soft or disposable).

Conditions for Reimbursement

1) Vision services must be:

- billed for by a Provider in private practice; and
- services which the Provider is licensed to render.

Special Limits

1) Services required by Your employer as a condition of employment or rendered through a medical department, clinic, or other similar services provided or maintained by the employer are excluded.

2) Sunglasses, even if by prescription, are excluded.

3) Benefits will not be provided for more than the following in a 24 month period.

- one routine vision examination
- one pair of frames
- one pair of non-contact lenses, regardless of the type of lenses, or
- contact lenses (hard, soft, or disposable).

Reimbursement

Refer to the Summary of Benefits insert for Key Advantage Expanded and Key Advantage 200.

OUTPATIENT PRESCRIPTION DRUGS
(Mandatory Generic Program)

Administered by Medco Health Solutions, Inc.

Services Which Are Eligible for Reimbursement

Medco Health administers Your benefits for Outpatient prescription drugs received through a retail pharmacy or the Medco Health Home Delivery Pharmacy Service. Your Plan covers prescription drugs if received through a pharmacy or a Hospital. If You receive prescription drugs from Your Hospital, they will be covered as a Hospital service.

Also covered are prescription drugs and devices approved by the Food and Drug Administration (FDA) for use as contraceptives, and outpatient prescription drugs for smoking cessation.

Benefits provide for the following to treat diabetes:

- insulin
- lancets;
- hypodermic needles and syringes;
- blood glucose test strips; and
- blood glucose meters

Conditions for Reimbursement

The drugs must:

- by federal or State law, require a prescription order to be dispensed;
- be approved for general use by the U. S. Food and Drug Administration;
- be prescribed by a Provider licensed to do so;
- be furnished and billed by a pharmacy for Outpatient use; and
- be Medically Necessary.

Special Limits

1) A 34-day supply will be eligible for reimbursement from a retail pharmacy.

2) A 35- to 90-day supply is eligible for reimbursement from a retail pharmacy.

3) A supply of up to 90 days may be obtained from the mail service pharmacy.

4) Only in documented cases of extended foreign travel will a supply of more than 90 days be prior authorized.

5) Replacement drugs for supplies lost, stolen, etc. are not eligible for reimbursement.

6) Benefits for any refill of a prescription drug will not be provided until the amount of time has elapsed from the previous dispensing of the prescription drug which would result in at least 75% of the drug being used if taken consistently with the prescribing Provider's directions.

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.

8) Certain drugs may not be available through the home delivery pharmacy service 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.

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.

Reimbursement

Refer to the Benefits Summary insert for the Plan in which You are enrolled for the Copayment by tier.

1) After the Copayment, the Plan Administrator pays 100% of the Allowable Charge. The Plan Administrator will determine whether a particular generic prescription drug is equivalent to a brand name prescription drug. If You or Your Provider determine to fill the prescription with a brand name drug when a generic equivalent is available, You will be responsible not only for the Copayment, but also the difference between the Allowable Charge for the brand name drug and the Allowable Charge of its generic equivalent.

2) If the dispensing pharmacy is a Network pharmacy, the Plan Administrator will direct benefit payment to that pharmacy. If the dispensing pharmacy is a Non Network pharmacy, the Plan Administrator will direct payment to the Member.

   - a Network pharmacy is a pharmacy listed as a Network pharmacy by the Plan Administrator at the time the prescription drug is dispensed.
   - a Non-Network pharmacy is any other pharmacy. You may be required by a Non Network pharmacy to pay not only the Copayment, but also the difference between the pharmacy's charge for the prescription drug and the Allowable Charge for the prescription drug.

3) The benefits provided for services under this section are in lieu of any other benefits for the same services listed in any other section of this booklet. Any Copayment listed for prescription drug services will not be eligible for reimbursement as a covered service under any other section.

4) The Plan Administrator may receive, directly or indirectly, financial credits from drug manufacturers whose products are included on formulary lists. Credits are received based on the utilization of the manufacturer's products by persons enrolled under contracts insured by or administered by the Plan Administrator. Credits received by virtue of the benefits provided under this section are retained by the Plan Administrator as a part of its compensation from the State for administrative services. Payments to pharmacies are not adjusted as a result of these credits.

DENTAL SERVICES

Administered by Delta Dental Plan of Virginia

Services Which Are Eligible for Reimbursement

Diagnostic and preventive care (routine)

Your Plan provides coverage for You to see Your dentist twice a year for a checkup. This allows Your dentist to identify any possible problems and to try and prevent cavities and serious dental problems. Covered services include:

- two routine oral evaluations per Plan Year;
- two dental prophylaxes (cleanings) per Plan Year, including scaling and polishing of teeth;
- dental x-rays (except x-rays needed to fit braces);
- space maintainers used to keep teeth from moving into space left when deciduous teeth are pulled;
- two tests to see if a tooth is still alive (pulp vitality tests) every 12 months (the 12-month count starts the month in which You receive the pulp vitality test);
- care for a toothache (palliative Emergency care);
- 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);
- two topical fluoride applications per Plan Year only to covered persons under age 19;
- dental pit/fissure sealants to the unrestored occlusal surface of the first and second permanent molars (limited to one application per tooth). Dental pit/fissure sealants are available only to covered persons under age 19;
- occlusal adjustments, bite planes or splints for temporomandibular joint disorders;
- occlusal night guards for demonstrated tooth wear due to bruxism and temporomandibular joint disorder (TMJ). Services are limited to once every five-year period.

Basic dental care (routine)

After Your dentist has examined Your teeth, You may need additional dental work. Your Plan includes coverage for the following:

- fillings (amalgam or tooth-colored materials);
- pin retention;
- simple extractions of natural teeth and surgical extractions of fully erupted teeth;
- root canal therapy (endodontics);
- care for abscesses in the mouth (excision and drainage);
- repair of broken removable dentures;
- surgical preparation of ridges for dentures;
- re-cementing existing crowns, inlays and bridges;
- removing infected parts of the gum and replacing them with healthy tissue (gingivectomy and gingivoplasty);
- scaling and root planing of the gum;

- stainless steel crowns;
- sedative fillings;
- therapeutic pulpotomy for primary "baby" teeth only;
- periodontal evaluation (not in addition to periodic evaluations);
- an operation to remove diseased portions of bone around the teeth (osseous surgery);
- soft tissue grafts;
- bone graft (only around natural teeth)
- guided tissue regeneration;
- general anesthesia in connection with a covered surgical dental service;
- crown lengthening when bone is removed and at least six weeks are allowed for healing;
- frenectomies;
- hemisection and root amputations;
- apicoectomies;
- periodontal maintenance (limited to two per Plan Year); and
- trips by the dentist to Your home if You need any of the services You see listed here.

Major dental care (routine)

If preventive care fails to save a tooth, major dental care is provided as follows:

- inlays (limited to the benefit for a resin restoration unless part of partial or bridge abutment);
- onlays (limited to the benefit for a metallic restoration);
- crowns, crown repair, and post and core build-ups for crowns;
- labial veneers involving the incisal edge of anterior teeth, porcelain laminate (Laboratory processed);
- dental implants;
- dentures (full and partial), and denture adjustments and relining; and
- fixed bridges and repair.

Delta Dental must approve permanent crowns for covered persons under age 16 in advance. Replacement of prosthetic appliances, dentures, crowns, crown buildups, post and core to support crowns, onlays and bridges are limited to once every five-year period. There is one exception: Replacement of a bridge will be provided prior to the end of the five-year period if one or more abutment teeth are extracted.

Orthodontic benefits (routine)

This provides coverage for orthodontic benefits. Benefits are available if the problem is a handicapping malocclusion. That means it prevents normal chewing or eating. Your coverage includes:

- orthodontic appliances (installing only, no replacement or repair);
- services needed to diagnose the problem, including x-rays, study model and diagnostic casts;
- tooth guidance and harmful habit appliances;
- interceptive treatment;
- surgical access of unerupted teeth when performed for orthodontic purposes; and
- orthodontic evaluations when no treatment is initiated.

Dental services (non-routine)

Your Plan also provides coverage for the following non-routine dental services through the Anthem medical benefits. The services listed below are covered as Other Covered Services and are subject to the medical Plan Year Deductible and Out-of-Pocket Expense Limit:

- Medically Necessary dental services resulting from an accidental injury, provided that 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.
- Medically Necessary dental services when required to diagnose or treat an accidental injury to the teeth if the accident occurs while You are covered under the Plan. These services and appliances are covered for adults if rendered within a two-year period after the accidental injury. The 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 six 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;
- the repair of dental appliances damaged as a result of accidental injury to the jaw, mouth or face;
- dental services and dental appliances furnished when required to treat medically diagnosed cleft lip, cleft palate, or ectodermal dysplasia; and
- dental services to prepare the mouth for Radiation Therapy to treat head and neck cancer.

The following services are covered as professional Provider or facility services subject to the specialty care Provider or facility Copayment, and the Plan Year Deductible does not apply:

- 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 only provided when it is determined by a licensed dentist, in consultation with the covered person's treating Physician, that such services are required to effectively and safely provide dental care.

Special Limits

1) A Plan Year dental Deductible applies to routine dental coverage. Refer to the Benefits Summary insert for the Plan in which You are enrolled.

2) There is a Plan Year benefit maximum for routine dental benefits and a lifetime maximum benefit for orthodontic benefits. Refer to the Benefits Summary insert for the Plan in which You are enrolled.

3) If general Anesthesia Services are rendered by the same dentist who performs the dental treatment, the Allowable Charge for the services will be 50% of the amount it would have been for them if rendered by someone else.

4) If You transfer from the care of one dentist to another during a course of treatment, the Plan Administrator will only pay the amount it would pay to one dentist for the same treatment.

5) If more than one dentist renders services for one procedure, the Plan Administrator will only pay the amount it would pay to one dentist for the same treatment.

6) If dental services for a single procedure or series of procedures cost more than $250, Your dentist may submit a predetermination Plan to Delta Dental before services are provided.

By submitting a predetermination Plan, You and Your dentist will be informed of: the total costs associated with the procedure(s); the exact amounts that will be covered by Your Plan; and the portion of the charges for which You will be responsible. A predetermination Plan is not required by Plan, but recommended when extensive dental work is expected. A claim will not be denied for failure to obtain a predetermination Plan.

Reimbursement

Refer to the Benefits Summary insert for the Plan in which You are enrolled.

OTHER COVERED SERVICES
(Formerly known as Major Medical Services)

Medical Services administered by Anthem Blue Cross and Blue Shield; Behavioral Health Services administered by ValueOptions, Inc.

Services Which Are Eligible for Reimbursement

The following Other Covered Services (referred to as "certain medical services" in the Benefits Summary insert) are eligible for reimbursement.

1) Ambulance services are eligible for reimbursement when used locally to or from a covered facility or Provider's office.

2) The cost of fitting, adjustment, and repair of the following items when prescribed by Your doctor for activities of daily living:

   - artificial limbs, including accessories;
   - orthopedic braces;
   - leg braces, including attached or built-up shoes attached to the leg brace;
   - arm braces, back braces and neck braces;
   - head halters;
   - catheters and related supplies;
   - orthotics, other than foot orthotics; and
   - splints
   - breast prostheses.

Medical necessity review is required. Contact Anthem member services at **800-552-2682**.

4) Medical supplies are covered if they are prescribed by a covered provider. Some medical supplies require medical necessity review. An example of medical supplies is oxygen and equipment (respirators) for its administration.

5) The rental (or purchase if that would be less expensive) of medical equipment (durable) when prescribed by Your doctor. Also covered are maintenance and necessary repairs of medical equipment (durable) except when damage is due to neglect. Medical necessity review is required. Contact Anthem member services at **800-552-2682** for assistance with medical necessity review. Network medical equipment (durable) providers are shown in the Anthem Commonwealth of Virginia and The Local Choice Medical Provider Directory under Ancillaries, Durable Medical Equipment. If You obtain equipment from a non-network medical equipment (durable) provider, You will still have coverage. However, in addition to Your deductible and coinsurance, the non-network provider may bill You for the difference between the Allowable Charge and the provider’s charge.

   Coverage includes equipment such as:

   - nebulizers;
   - hospital-type beds;
   - wheelchairs;
   - traction equipment;
   - walkers; and
   - crutches.

6) Special medical formulas which are the primary source of nutrition for covered persons with inborn errors of amino acid or organic acid metabolism, metabolic abnormality or severe protein or soy allergies. These formulas must be prescribed by a physician and required to maintain adequate nutritional status.

7) Covered diabetic equipment includes:

- insulin pumps and associates supplies;
- lancet devices; and
- calibrator solution.

8) Prescribed services performed by a licensed private duty nurse.

9) Intrauterine devices (IUDs).

10) The following prescribed eyeglasses or contact lenses are eligible for reimbursement:

a. eyeglasses or contact lenses which replace human lenses lost as the result of intra-ocular surgery or injury to the eye

b. "Pinhole" glasses used after surgery for a detached retina

c. lenses used instead of surgery, such as:

- contact lenses for the treatment of infantile glaucoma
- corneal or sceleral lenses in connection with keratoconus
- sceleral lenses to retain moisture when normal tearing is not possible or is not adequate
- corneal or sceleral lenses to reduce a corneal irregularity (other than astigmatism)

A maximum of one set of eyeglasses or one set of contact lenses will be covered for Your original prescription or for any change in Your original prescription. Examination and replacement for a prescription change are covered only when the change is due to the condition for which You needed the original prescription.

11) Early Intervention Services as described in the Definitions section.

12) Special medical formulas which are the primary source of nutrition for Yourself or covered family members with inborn errors of amino acid or organic acid metabolism, metabolic abnormality or severe protein or soy allergies are covered. These formulas must be prescribed by a Physician and required to maintain adequate nutritional status.

13) Bed and board in a Semi-Private Room, including general nursing services and special diets. A bed in an intensive care unit is eligible for reimbursement for critically ill patients. Your Plan covers the charge for a private room if You need a private room because You have a highly contagious condition, You are at greater risk of contracting an infectious disease because of Your medical condition; or if the Hospital only has private rooms. Otherwise, You have coverage for a Semi-Private Room. If You choose to occupy a private room, You will be responsible for paying the daily differences between the semi-private and private room rates in addition to any Copayment or Coinsurance that may apply.

14) Customary ancillary services for Inpatient Stays, including operating rooms, medications, oxygen and oxygen tents, dressings and casts, anesthesia, transfusions, blood, blood plasma, blood derivatives, blood volume expanders, and professional donor fees, Diagnostic Tests and Therapy Services, Emergency room services leading directly to admission or to death, ambulance services for transportation between local Hospitals when Medically Necessary, and routine nursery care of a newborn as part of a mother's covered Maternity Service.

15) Outpatient Hospital services including pre-admission testing and other Diagnostic Tests, Therapy Services, Shots, Surgery Services, Inpatient ancillary services when unavailable in an Inpatient facility, mammography, and Partial Hospitalization for Behavioral Health Services.

16) Home health care services are covered only if You do not have Visits available under the home health care services section.

17) Inpatient and Outpatient Medical, and Surgical Services.

18) Outpatient Diagnostic Tests.

19) Outpatient Therapy Services. Under this section, services may be furnished and billed for by a registered occupational therapist, a certified speech therapist, or a certified inhalation therapist.

20) 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 are eligible for reimbursement if a Plan of Treatment from the dentist or oral surgeon is submitted to Anthem 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.

    Other Covered 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.

21) Emergency services in an Emergency room, whether or not leading to a Hospital admission.

Conditions for Reimbursement

1) With respect to private duty nursing services, only services by a Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.) are covered. Also,

   - these services must be Medically Necessary;
   - the nurse may not be a relative or member of Your family;
   - Your Provider must explain why the services are required; and
   - Your Provider must describe the Medically Skilled Service provided.

2) For medical equipment (durable), Your Provider must, upon request, explain why the equipment is needed and how long it will be used.

3) For coverage of ambulance services:

   - The trip to the facility or office must be to the nearest one recognized by the Plan Administrator as having services adequate to treat Your condition.
   - The services You receive in that facility or Provider's office must be covered services.
   - If the Plan Administrator requests it, the attending Provider must explain why You could not have been transported in a private car or by any other less expensive means.

4) The Other Covered Services discussed in this section are not eligible for reimbursement if the same service is available under some other section of this booklet. The Plan Administrator will pay only once for a service and will not increase or extend benefits available under other sections of this contract.

5) Behavioral Health, dental, and outpatient prescription drug services are not available for reimbursement under Other Covered Services.

6) The following and similar items are not eligible for reimbursement as medical equipment (durable):

   - exercise equipment
   - air conditioners
   - dehumidifiers and humidifiers
   - whirlpool baths
   - handrails
   - ramps
   - elevators
   - telephones
   - adjustments made to a vehicle

7) The Plan Administrator will not pay for any equipment which has both a non-therapeutic and therapeutic use. The Plan Administrator will pay for the least expensive item of equipment required by Your medical condition. If the Plan Administrator determines that purchase of the medical equipment (durable) is less expensive than rental, or if the equipment cannot be rented, the Plan Administrator may approve the purchase as a covered service.

8) No claim for Other Covered Services will be paid if the Plan Administrator receives it more than one year after the end of the calendar year in which the service was rendered.

Deductible

You must pay a Plan Year Deductible before You are eligible for reimbursement for covered benefits under this section. Refer to the Benefits Summary insert for the Plan in which You are enrolled.

Reimbursement

Refer to the Benefits Summary insert for the Plan in which You are enrolled.

INDIVIDUAL CASE MANAGEMENT PROGRAM

Medical Services administered by Anthem Blue Cross and Blue Shield; Behavioral Health Services administered by ValueOptions, Inc.

Services Which Are Eligible for Reimbursement

Individual case management is included under Your Medical and Behavioral Health benefits. In addition to the covered services listed in this booklet, Your Plan may elect to offer benefits for an approved alternate treatment Plan for a patient who would otherwise require more expensive covered services. This includes, but is not limited to, long term Inpatient care. Your Plan will provide alternate benefits at its sole discretion. It will do so only when and for so long as it decides that the services are Medically Necessary and cost effective. The total benefits paid for such services may not exceed the total that would otherwise be paid without alternate benefits. If Your Plan elects to provide alternate benefits for a covered person in one instance, it will not be required to provide the same or similar benefits for any covered person in any other instance. Also, this will not be construed as a waiver of Your Plan's right to enforce the terms of Your Plan in the future in strict accordance with its express terms.

Also, from time to time Your Plan may offer a covered person and/or their Provider or facility information and resources related to disease management and wellness initiatives. These services may be in conjunction with the covered person's medical condition or with therapies that the covered person receives, and may or may not result in the provision of alternative benefits as described in the preceding paragraph.

BLUECARD PROGRAM

For Medical Services administered by Anthem Blue Cross and Blue Shield

BlueCard® PPO for Care within the United States

Anthem Blue Cross and Blue Shield does business only within a certain geographic area in the Commonwealth of Virginia. If You live or travel outside our area, You still have the freedom to receive care from any provider or facility. Keep in mind, You should receive care from a provider or facility who participates in a Blue Cross Blue Shield company's BlueCard PPO network to receive the highest level of benefits. Your health Plan includes a program called "BlueCard," which provides You and Your covered family members with the benefits of using selected PPO network providers and facilities outside our area. Generally, Blue Cross Blue Shield PPO network providers and facilities who participate in BlueCard will accept Your Copayment or Coinsurance at the time of services instead of requiring full payment. Most of these providers or facilities will file claims for You and most have agreed to accept the Allowable Charge established by their local Blue Cross and/or Blue Shield Plan as payment in full for their services.

> **Helpful tip**: In the event that You travel outside of Virginia and receive services with more than one Blue Plan network, an exclusive network arrangement may be in place. If You see a provider who is not part of an exclusive network arrangement, that provider's service(s) will be considered out-of-network care, and You may be billed the difference between the charge and the Allowable Charge. You may call Member Services or go to **www.anthem.com/tlc** for information regarding such arrangements.

To locate a BlueCard PPO Physician or Hospital call **800-810-BLUE (2583)**. Or use the BlueCard Doctor and Hospital Finder on the Web at **www.bcbc.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 medical plan includes the BlueCard PPO program.

How Charges Are Calculated for BlueCard PPO Services

If the amount You pay for a covered service is based on the charge for that service, the charge used to calculate Your part will be the lower of:

- the billed charge for the covered service; or
- the negotiated price passed on to us by the local Blue Cross and/or Blue Shield Plan. Often, this "negotiated price" will consist of a simple discounted price, but it can also be an estimated or average price allowed under the BlueCard Program and applied under the terms of Your medical 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 payment. 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. More detailed information about negotiated prices is included in the group policy.

Laws in a small number of states may require the local Blue Cross and/or Blue Shield Plan to:

- use another method for, or
- add a surcharge to, Your liability calculation.

If any state laws mandate other liability calculation methods, including a surcharge, Anthem Blue Cross and Blue Shield would then calculate Your liability for any covered health care services 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" then "PPO Coverage". Or You may call **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 BlueCard Worldwide Service Center at **804-673-1177** (use a local operator to set up a collect call to the U.S.). A BlueCard Worldwide Service Center representative will accept the charges and will facilitate hospitalization at a BueCard 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 Member Services at **804-355-8506** for Hospital admission review.

Inpatient Hospital care (emergency):
Bypass the above steps. Go to the nearest Hospital. Call the BlueCard Worldwide Service Center at **804-673-1177** (use a local operator to set up a collect call to the U.S.) 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/Physicians services:

1. Call the BlueCard Worldwide Service Center at **804-673-1177** (or use a local operator to set up a collect call to the U.S.) if You would like information on Physicians or

Outpatient facilities. A BlueCard Worldwide Service Center representative will accept the charges, and if You want, 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", then "I need health care outside of the U.S.".

PROGRAMS INCLUDED IN YOUR HEALTH PLAN

ValueOptions, Inc. Employee Assistance Program (EAP)

The EAP provides up to four counseling sessions per incident free of charge. Your behavioral health Provider will determine the number of sessions (up to four) that are appropriate for Your care. Contact ValueOptions toll-free at **866-725-0602** for more information.

CommonHealth Wellness Program

This program is designed to make a positive difference in your health by integrating health awareness into the workplace. CommonHealth features a variety of medical screenings, including cholesterol and blood pressure; challenges; health education programs and other activities. For more information, visit **www.dhrm.virginia.gov** and click on the CommonHealth link. This program is not generally available to retirees, survivors and LTD participants.

24/7 NurseLine and AudioHealth Library

Illness or injury can happen, no matter what time of day. As an Anthem health plan member, You have access to a team of nurses, available to assist with your questions or concerns, 24 hours a day, seven days a week. These registered nurses can discuss symptoms You are experiencing, how to get the right care in the right setting and more. You can call as often as You like. Call **800-337-4770**.

For those who aren't comfortable discussing their health concerns with someone else or those just looking for more information on a health topic, the AudioHealth Library has more than 300 recorded health topics. Call **800-337-4770** to access this line. For the list of topics, go to **anthem.com/tlc** and select AudioHealth Library under Special Programs.

Future Moms

You (or your covered dependent) are eligible to participate in the Future Moms program. This free program is designed to help women have healthy pregnancies and healthy babies. A Future Moms registered nurse is assigned to women identified as having greater risk of premature delivery. The nurse works with the mother and her doctor throughout the pregnancy to help avoid complications and to help ensure that the baby is born at a healthy weight.

As soon as pregnancy is confirmed, sign up for the program by calling **800-828-5891**. You will receive:

- toll-free access to a registered nurse, any time day or night, in case You have questions or concerns along the way;
- a prenatal book to help You follow your pregnancy week by week, materials to help You handle the unexpected; and
- postpartum support and guidance in areas like breastfeeding and depression.

If you are covered by Key Advantage Expanded or Key Advantage 200, Your Health Plan may waive all or part of the maternity hospital stay copayment when you enroll in Future Moms. To be eligible, you must:

- Enroll in Future Moms during the first trimester of pregnancy; and
- Actively participate and complete all program requirements.

Call **1-800-828-5891** to enroll and receive additional information.

ConditionCare

If You or a family member are living with asthma, diabetes, coronary artery disease (CAD), heart failure, chronic obstructive pulmonary disease (COPD), hypertension, hyperlipidemia, or obesity, You know the impact that it has on your life. This confidential disease management program will provide the tools and support needed to minimize your condition's effects, improve your health and help You feel better.

ConditionCare is a voluntary program. To register in this program, call **800-445-7922**. A dedicated nurse will be available to answer your questions, help You coordinate your benefits, and provide support to help You follow your doctor's plan of treatment. When You call, please be sure to have your health insurance ID card and physician's name and address available.

In addition to members calling to enroll, the program receives the names of members who may have certain chronic health conditions from medical and pharmacy claims, and case managers. You may be contacted by a ConditionCare enrollment specialist to find out if You or any of your eligible family members would like to participate in this program. With your permission, your health care information will be verified and will be shared with the ConditionCare staff and your physician. If your condition is under control or You are not interested in participating in the program, feel free to contact ConditionCare at **800-445-7922** to notify an enrollment specialist that You are not interested and do not wish to be contacted further.

Healthy Smile, Healthy You™

Growing evidence connects oral health to overall general health. Delta Dental of Virginia's Healthy Smile, Healthy You™ provides additional benefits for two important health conditions connected to oral health: pregnancy and diabetes.

- Pregnant members enrolled in the Future Moms program are eligible for one additional cleaning or periodontal maintenance procedure during the term of their pregnancy, in addition to the normal plan frequency limits.
- Diabetic members enrolled in the ConditionCare program are eligible for one additional cleaning or periodontal maintenance procedure during the plan year.

See the information in this section on enrolling in the Future Moms or ConditionCare programs.

Medco Special Care Pharmacy Service

When You receive Your specialty prescription drugs through the Medco By Mail home delivery pharmacy, the Medco Special Care Pharmacy program provides You with personal counseling from nurses, registered pharmacists and patient care representatives who are trained in specialty medications. Specialty medications are drugs such as Procrit® to treat anemia, Betaseron® for multiple sclerosis and Ebrel® or Remicade® for rheumatoid arthritis. The program includes 24-hour access to a Medco Special Care Pharmacy pharmacist and free supplies needed to administer Your medicine, such as needles and syringes.

Call toll-free **800-803-2523** to order Your specialty medication. Medco will call Your doctor for a new prescription. Or if You prefer, Your doctor's office may call the Medco Special Care Pharmacy directly at **800-987-4904**. More information is available at **www.medco.com**.

EXCLUSIONS

This is a list of services which are not, under any circumstances, eligible for reimbursement.

A

Your coverage does not include benefits for **acupuncture**.

B

Your coverage with ValueOptions, in addition to services shown as not covered throughout this section, does not include benefits for **Behavioral Health Services** as follows:

- Inpatient treatment or Inpatient Stay for conditions requiring only observation, diagnostic examinations, or diagnostic laboratory testing;
- Inpatient treatment which might safely and adequately be rendered in a home, Provider's office, or at any lesser level of institutional care;
- Inpatient rehabilitation for the sole treatment of a chemical dependency diagnosis;
- services provided as a result of failure or refusal to obtain treatment or follow a Plan of Treatment prescribed or directed by a practitioner;
- court ordered examinations or care unless Medically Necessary;
- routine examinations or testing (may be covered under medical);
- illness resulting from or relating to a felony;
- treatment of organic brain syndrome;
- treatment of anti-social personality, inadequate personality, sexual deviation or sexual dysfunction, social maladjustment without apparent psychiatric disorder, group delinquent reaction of childhood, mental retardation, Tourette's disorder, learning disabilities, and conduct and oppositional disorders;
- examination of an Inpatient that is not related to the behavioral health diagnosis;
- marital counseling, education therapy, Speech Therapy, behavior therapy, vocational therapy, coma-stimulation therapy, activities therapy, and recreational therapy;
- psychoanalysis to complete degree or residency requirements;
- pastoral counseling;
- psychological testing for educational purposes;
- hypnosis for disorders not classified in the Diagnostic and Statistical Manual of Mental Disorders;
- treatment of conditions not recognized in the Diagnostic and Statistical Manual of Mental Disorders such as adult child of alcoholic families, "ACOA", or co-dependency; conditions classified as "V-codes" in the Diagnostic and Statistical Manual of Mental Disorders; and conditions arising from developmental disorders (mental retardation, academic skills disorders, motor skills disorders, and organic brain disorders in which demonstrable and significant improvement from psychiatric treatment is unlikely);

Your coverage does not include benefits for **biofeedback therapy**.

C

Your coverage does not include benefits for:

- over-the-counter **convenience** and hygienic items. These include, but are not limited to, adhesive removers, cleansers, underpads, and ice bags; or
- **Cosmetic Surgery or procedures, including complications** that result from such surgeries and/or procedures. The severity of the complication is not a mitigating factor. Cosmetic surgeries and procedures are performed mainly to improve or alter a person's appearance including body piercing and tattooing. A Cosmetic Surgery or procedure does not include a surgery or procedure to correct deformity caused by disease, trauma, or a previous therapeutic process, or to correct congenital abnormalities that cause functional impairment. We will not consider the patient's mental state in deciding if the surgery is cosmetic.

D

Your coverage does not include benefits for the following **dental** services:

- dental supplies;
- brush biopsies of the oral cavity;
- services rendered after the date of termination of the covered person's coverage. There is one exception. Covered prosthetic services which are prepped or ordered before the termination date are covered if completed within 30 days following the termination date;
- gold foil restorations;
- athletic mouth guards;
- temporary dentures, crowns or duplicate dentures;
- oral, inhalation or intravenous (IV) sedation;
- bleaching of discolored teeth;
- dental pit/fissure sealants on other than first and second permanent molars;
- root canal therapy on other than permanent teeth;
- pulp capping (direct or indirect);
- upgrading of working dental appliances;
- precision attachments for dental appliances;
- tissue conditioning;
- separate charges for infection control procedures and procedures to comply with OSHA requirements;
- separate charges for routine irrigation or re-evaluation following periodontal therapy;
- analgesics (nitrous oxide);
- general anesthesia except in conjunction with oral surgery, surgical periodontia, or surgical endodontia and then only when the underlying dental service is a covered benefit;
- diagnostic photographs;
- periodontal splinting and occlusal adjustments for periodontal purposes;
- occlusal analysis;
- controlled release of medicine to tooth crevicular tissues for periodontal purposes;
- tooth desensitizing treatments;
- care by more than one dentist when You transfer from one dentist to another during the course of treatment;

- care by more than one dentist for one dental procedure, or by someone other than a dentist or qualified dental hygienist working under the supervision of a dentist;
- preventive control programs, or oral hygiene instructions;
- complimentary services or dental services for which the Participant would not be obligated to pay in the absence of the coverage under this Plan or any similar coverage;
- dental services for lost, misplaced or stolen prosthetic devices including orthodontic retainers, space maintainers, bridges and dentures (among other devices);
- services that Delta Dental determines are for the purpose of Cosmetic Surgery or dentistry for cosmetic purposes;
- services that Delta Dental determines are for the purpose of correcting congenital malformations or replacing congenitally missing teeth;
- dental services for increasing vertical dimension, restoring occlusion, correcting developmental malformations, or for esthetic purposes;
- services billed under multiple dental service procedure codes which Delta Dental, in its sole discretion, determines should have been billed under a single, more comprehensive dental service procedure code. Delta Dental's payment is based on the allowance for the more comprehensive code, not on the allowances for the underlying component codes, and;
- any services not listed as covered under **Dental services** in the **What is covered** section or services determined by Delta Dental, in its sole discretion, to be not necessary or customary for the diagnosis or treatment of the condition. Delta Dental will take into account generally accepted dental practice standards in the area in which the dental service is provided. In addition, a covered person must have a valid need for each covered benefit. A valid need is determined in accordance with generally accepted standards of dentistry.

E

Your coverage does not include benefits for **educational** or teacher services except as specified in this booklet.

Your medical coverage does not include benefits for **Experimental/Investigative** procedures, as well as services related to or complications from such procedures, except for Clinical Trial Costs for cancer. The criteria for deciding whether a service is Experimental/Investigative or a Clinical Trial Cost for cancer is described in the Definitions section of this booklet.

Your behavioral health coverage does not include benefits for **Experimental/Investigative** services or supplies as determined by ValueOptions in its sole discretion. The criteria for this determination is whether any supply or drug has received final approval to market by the U.S. Food and Drug Administration; whether there is sufficient information in the peer-reviewed medical and scientific literature for ValueOptions to judge safety and efficacy; whether available scientific evidence shows a good effect on health outcomes outside of a research setting; and whether the service or supply is safe and effective outside a research setting as a current diagnostic or therapeutic option.

F

Your coverage does not include benefits for **family planning** services. These include:

- 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;
- medications used to treat infertility even if they are used for an indication other than fertility; or
- services for abortions, except in the following circumstances and only if not otherwise contrary to law: when Medically Necessary to save the life of the mother; when the pregnancy occurs as a result of rape or incest which has been reported to a law enforcement or public health agency; or when the fetus is believed to have an incapacitating physical deformity or incapacitating mental deficiency which is certified by a Provider.

Your coverage does not include benefits for palliative or cosmetic **foot care** including:

- 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 (except as treatment for patients with diabetes or vascular disease);
- bunions (except capsular or bone surgery);
- calluses (except capsular or bone surgery);
- care of toenails (except capsular or bone surgery);
- fallen arches;
- weak feet;
- chronic foot strain; or
- symptomatic complaints of the feet.

H

Your coverage does not include benefits for routine **hearing care** (except as covered under Well Child services), or hearing aids or exams for these devices.

Your coverage does not include benefits for the following **home care** services:

- homemaker services;
- maintenance therapy;
- food and home-delivered meals; or

Your coverage does not include benefits for the following **Hospital** Services:

- guest meals, telephones, televisions, and any other convenience items received as part of Your Inpatient Stay; or
- care by interns, residents, house Physicians, or other facility employees that are billed separately from the facility.

M

Your coverage does not include benefits for **medical equipment (durable), appliances and devices, and medical supplies** that have both a non-therapeutic and therapeutic use, such as:

- exercise equipment;
- air conditioners, dehumidifiers, humidifiers, and purifiers;
- hypoallergenic bed linens;
- whirlpool baths;
- handrails, ramps, elevators, and stair glides;
- telephones;
- adjustments made to a vehicle;
- foot orthotics;
- changes made to a home or place of business; or
- repair or replacement of equipment You lose or damage through neglect.

Your coverage does not include benefits for services and supplies if they are deemed not Medically Necessary as determined by Anthem or ValueOptions at their sole discretion. Nothing in this exclusion shall prevent You from appealing Anthem or ValueOptions' decision that a service is not Medically Necessary.

However, if You receive Inpatient or Outpatient services that are denied as not **Medically Necessary**, or are denied for failure to obtain the required authorization, 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 rendering services in an (i) Outpatient Hospital setting, (ii) Emergency room, or (iii) ambulatory surgery setting. However, this exception does not apply if and when any such pathologist, radiologist or anesthesiologist assumes the role of attending Physician.

N

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.

O

Your coverage does not include benefits for care of obesity or services 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.

An exception to this exclusion is Morbid Obesity as set forth in the "**Hospital Services**" section of this handbook.

Coverage is provided for treatment of Morbid Obesity through gastric bypass surgery or other methods recognized by the National Institutes of Health (NIH) as effective treatment for the long-term reversal of Morbid Obesity for a patient who:

- weighs at least 100 pounds over or twice the ideal body weight;
- 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.

The exception to this exclusion is for Morbid Obesity as set forth in the Hospital Services section of this handbook.

Your coverage does not include benefits for **organ or tissue transplants** including complications caused by them, except as outlined under the General Rules Governing Benefits section.

P

Your coverage does not include benefits for **paternity testing**.

Your **prescription drug** benefit does not include coverage for:

- 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, except in conjunction with covered treatment of Morbid Obesity;
- 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; or
- medications used to treat infertility even if they are used for an indication other than fertility.

Your coverage does not include benefits for **private duty nurses** in the Inpatient setting.

R

Your coverage does not include benefits for rest cures, custodial, **residential**, halfway house 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 services. Your coverage does not include benefits for care from institutions or facilities that are licensed solely as **residential treatment centers**, intermediate care facilities, or other non-skilled, sub-acute Inpatient settings.

S

Your coverage does not include benefits for **services or supplies** as follows:

- ordered by a doctor whose services are not covered under Your 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 Plan;
- not prescribed, performed, or directed by a Provider licensed to do so;
- received before the Effective Date of coverage or after a covered person's coverage ends;
- telephone consultations or consultations by other electronic means, charges for not keeping appointments, or charges for completing claim forms;
- 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. This includes 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; or
- for diseases contracted or injuries caused because of participation in war, declared or undeclared, voluntary participation in civil disobedience, or other such activities.

Your coverage does not include benefits for services for which a charge is not usually made. This includes services for which You would not have been charged if You did not have health care coverage.

Your coverage does not include benefits for:

- amounts above the Allowable Charge for a service;
- self-administered services or self-care;

- self-help training; or
- biofeedback, neurofeedback, and related Diagnostic Tests.

Your coverage does not include benefits for surgeries for **sexual dysfunction**. In addition, Your coverage does not include benefits for services for **sex transformation**. This includes medical and Behavioral Health Services.

Your coverage does not include benefits for the following **Skilled Nursing Facility** Stays:

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

Your medical coverage does not include benefits for services related to **smoking cessation**, including stop smoking aids or services of stop smoking clinics, but may be covered under Your CommonHealth Wellness Program.

T

Your coverage does not include benefits for the following **Therapy Services**:

- 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; or
- recreation therapy. This includes, but is not limited to, sleep, dance, arts, crafts, aquatic, gambling, and nature therapy.

V

Your coverage does not include benefits for the following **vision services**:

- services for radial keratotomy and other surgical procedures to correct nearsightedness and/or farsightedness. This type of surgery includes keratoplasty and Lasik procedure;
- services for vision training and orthoptics;
- sunglasses of any type;
- services needed for employment or given by a medical department, clinic, or similar service provided or maintained by the employer; or
- any other vision services not specifically listed as covered.

W

Your coverage does not include benefits for 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.

BASIC PLAN PROVISIONS

1) The Department's Right to Change, End, and Interpret Benefits

This Plan is sponsored by the Commonwealth of Virginia (State) and administered by the Department of Human Resource Management. The Department is authorized to, and reserves the right to change or terminate this Plan on behalf of the Commonwealth at any time. These retained rights extend, without limit, to all aspects of the Plan, including, for example, benefits, eligibility for benefits, Provider Networks, premiums, Copayments and contributions required of employees. The Department is also authorized and empowered to exercise discretion in interpreting the terms of the Plan and such discretionary determination will be binding on all parties.

2) You and Your Provider

You have the right to select Your own Provider of care. Services provided by an institutional Provider are subject to the rules and regulations of the Plan You select. These include rules about admission, discharge, and availability of services. Neither the Plan Administrator, the State, nor The Local Choice Group guarantees admission or the availability of any specific type of room or kind of service. Neither the Plan Administrator, the State, nor The Local Choice Group will be responsible for acts or omissions of any facility. Neither the Plan Administrator, the State, nor The Local Choice Group will be liable for the negligence, misconduct, malpractice, refusal or inability to render services, or any other failing of a facility. Neither the Plan Administrator, the State, nor The Local Choice Group will be liable for breach of contract because of anything done, or not done, by a facility.

Similarly, the Plan Administrator is obligated only to pay, in part, for the services of Your professional Provider to the extent the services are covered. Neither the Plan Administrator, the State, nor The Local Choice Group guarantees the availability of a Provider's services. Neither the Plan Administrator, the State, nor The Local Choice Group will be responsible for acts or omissions of any Provider. Neither the Plan Administrator, the State, nor The Local Choice Group will be liable for the negligence, misconduct, malpractice, refusal or inability to render services, or any other failing of a Provider. Neither the Plan Administrator, the State, nor The Local Choice Group will be liable for breach of contract because of anything done, or not done, by a Provider. The same limitations apply to services rendered or not rendered by a Provider's Employee.

You must tell the Provider that You are eligible for services. When You receive services, show Your Plan identification card. Show only Your current cards.

3) Privacy Protection and Your Authorization

Information may be collected from other people and facilities. This is done in order to administer Your coverage. The information often comes from medical care facilities and medical professionals who submit claims for You. Collected information is generally disclosed to others only in accordance with the guidelines set forth in the Virginia Insurance Information and Privacy Protection Act. A more detailed explanation of the Plan Administrator's information practices is available upon request.

When You apply for coverage under The Local Choice Health Benefits Program, You agree that the Plan Administrator may request any medical information or other records from any source when related to claims submitted to the Plan Administrator for services You receive.

By accepting coverage under The Local Choice Health Benefits Program, You authorize any individual, association, or firm which has diagnosed or treated Your condition to furnish the Plan Administrator with necessary information, records, or copies of records. This authorization extends to any person or organization which has any information or records related to the service received or to the diagnosis and treatment of Your condition.

If the Plan Administrator asks for information and does not receive it, payment cannot be made. The claim will be processed only when the requested information or record has been received and reviewed.

Medical information is often highly confidential. You are entitled to review or receive only copies of medical information which applies to You. But, subject to the above, a Member may review copies of medical records which pertain to enrolled dependent children under age 18 as allowed by law.

4) The Personal Nature of These Benefits

Plan benefits are personal; that is, they are available only to You and Your covered dependents. You may not assign (give to another person) Your right to receive services or payment, except as provided in law. Prior payments to anyone will not constitute a waiver of or in any way restrict the Plan Administrator's right to direct future payments to You or any other individual or facility, even if there has been an assignment of payment in the past. This paragraph will not apply to assignments made to dentists and oral surgeons.

You and the Plan Administrator agree that other individuals, organizations, and health care practitioners will not be beneficiaries of the payments provided under this contract. This explanation of services and payments available to You is not intended for anyone else's benefit. As such, no one else (except for Your personal representative in case of Your death or mental incapacity) may assert any rights described in this booklet or provided under the Plan.

5) Proof of Loss

In many cases, the facility or Provider will submit Your claim to the Plan Administrator. However, the Plan Administrator cannot process claims for You unless there is satisfactory proof that the services You received are covered. In most cases, "satisfactory proof " is a fully itemized bill which gives Your name, date of the service, cost of the service, and the diagnosis for the condition. In some cases, the Plan Administrator will need additional proof, such as medical information or explanations. Your cooperation may be requested. Your claim cannot be processed until the needed information is received. All claims information and explanations submitted to the Plan Administrator must be in writing.

6) Timely Filing of Claims

No claim (proof of loss) will be paid if we receive it more than 12 months after the date of service, except in the absence of legal capacity of the covered person. There is one exception. For Other Covered Services no claim will be paid if received more than 12 months after the end of the calendar year in which the Other Covered Services were received.

7) Payment Errors

Every effort is made to process claims promptly and correctly. If payments are made to You, or on Your behalf, and the Plan Administrator finds at a later date the payments were incorrect, the Plan Administrator will pay any underpayment. Likewise, You must repay any overpayment. A written notice will be sent to the Member if repayment is required.

8) Group Benefits Administrator and Other Plan Information

Your Group Benefits Administrator is the person appointed by Your employer to assist You with Your health care benefits. Your Group Benefits Administrator may also provide You information about Your benefits. If there is a conflict between what Your Group Benefits Administrator tells You and the Plan, Your benefits will, to the extent permitted by law, be determined on the basis of the language in this booklet. The Group Benefits Administrator is never the agent of the Plan Administrator.

The Plan Administrator may send notices intended for You to Your Group Benefits Administrator. You may be provided with another booklet, brochure, employee communication, or other material which describes the benefits available under the Plan. In the event of conflict between this type of information and the Plan, Your benefits will be determined on the basis of the language in this booklet.

9) General Notice of Extended Coverage Rights

This notice generally explains Extended Coverage, when it may become available to You and Your family, and what You need to do to protect the right to receive it. Only employers with 20 or more employees may offer Extended Coverage.

The right to Extended Coverage was created for private employers by federal law through the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), and these rights are reflected in the continuation coverage provisions of the Public Health Service Act that covers employees of state and local governments. Extended Coverage can become available to You when You would otherwise lose Your group health coverage. It can also become available to other members of Your family who are covered under the Plan when they would otherwise lose their group health coverage.

For additional information about Your rights and obligations under the Plan and under the law, You should contact Your designated Group Benefits Administrator.

What Is Extended Coverage?

Extended Coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, Extended Coverage must be offered to each person who is a "qualified beneficiary." You, Your spouse and Your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. These rights are also available to children covered through a Qualified Medical Child Support Order (QMCSO). Under the Plan, qualified beneficiaries who elect Extended Coverage must pay the full cost for Extended Coverage. Time limitations for making Extended Coverage premium payments will be included in the Election Notice provided at the time of the qualifying event.

If You are an employee, You will become a qualified beneficiary if You lose Your coverage under the Plan because of either one of the following qualifying events:

- Your hours of employment are reduced. This would include periods of leave without pay (even if the employer premium contribution continues for a designated period of time that runs concurrently with Extended Coverage) and any reduction of hours resulting in loss of coverage and/or loss of or change in the terms and conditions of the employer contribution toward the cost of coverage.
- Your employment ends for any reason other than Your gross misconduct.

If You are the spouse of an employee or retiree group participant, You will become a qualified beneficiary if You lose Your coverage under the Plan because of any one of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced (including periods of leave without pay, even if the employer premium contribution continues for a designated period of time that runs concurrently with Extended Coverage, and any reduction of hours resulting in loss of coverage and/or loss of or change in the terms and conditions of the employer contribution toward the cost of coverage);
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- You become divorced from Your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of any one of the following qualifying events:

- the parent/employee/retiree dies;
- the parent's/employee's hours of employment are reduced (including periods of leave without pay, even if the employer premium contribution continues for a designated period of time that runs concurrently with Extended Coverage, and any reduction of hours resulting in loss of coverage and/or loss of or change in the terms and conditions of the employer contribution toward the cost of coverage);
- the parent/employee's employment ends for any reason other than his or her gross misconduct;
- the parents become divorced, resulting in loss of dependent eligibility;
- the child stops being eligible for coverage as a dependent child under the plan.

Coverage that is terminated in anticipation of a qualifying event (e.g., divorce) is disregarded when determining whether the event results in a loss of coverage. If termination occurs under this condition but notification of the qualifying event is received from the employee, qualified beneficiary or a representative within 60 days of the date coverage would have been lost due to the qualifying event, Extended Coverage must be made available and effective on the date coverage would have been lost due to the event, but not before.

When Is Extended Coverage Available?
Your Group Benefits Administrator will automatically offer Extended Coverage to qualified beneficiaries upon the occurrence of the following qualifying events:

- termination of employment;
- reduction in hours of employment resulting in loss of coverage and/or loss of or change in the terms and conditions of the employer contribution toward the cost of coverage, including leaves without pay;
- death of the employee.

You Must Give Notice of Some Qualifying Events
For the other qualifying events (divorce of the employee and spouse or a dependent child's loss of eligibility for coverage as a dependent child), You or Your representative must notify Your Group Benefits Administrator within 60 days of the qualifying event (or

within 60 days of the date coverage would be lost due to the qualifying event) by submitting written notification to include the following information:

- the type of qualifying event (e.g., divorce, loss of dependent child's eligibility--including reason for the loss of eligibility);
- the name of the affected qualified beneficiary (e.g., spouse's and/or dependent child's name/s);
- the date of the qualifying event;
- documentation to support the occurrence of the qualifying event (e.g., final divorce decree, dependent child's marriage certificate);
- the written signature of the notifying party;
- if the address of record is incorrect, an address for mailing the Election Notice.

Failure to provide timely notice of these qualifying events will result in loss of eligibility for continuation coverage. One notice will cover all affected qualified beneficiaries. Notice will be considered furnished when mailed or, in the case of hand delivery, the date it is received by Your Group Benefits Administrator.

How Is Extended Coverage Provided?
Once Your designated Group Benefits Administrator becomes aware or is notified that the qualifying event has occurred, Extended Coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect Extended Coverage. Covered employees may elect Extended Coverage on behalf of an eligible spouse, and parents may elect Extended Coverage on behalf of their eligible children. Extended Coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee/retiree, Your divorce, or a dependent child's loss of eligibility as a dependent child, Extended Coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, Extended Coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before his coverage ends due to termination of employment, Extended Coverage for his covered spouse and/or children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date that coverage was lost due to termination of employment (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of employee's hours of employment, Extended Coverage may last for only up to a total of 18 months. There are two ways in which this 18-month period can be extended.

- **Disability extension of 18-month period of continuation coverage**
  You and anyone in Your family covered under the Extended Coverage provisions of the Plan (due to termination of employment or reduction of hours) may be entitled to receive up to an additional 11 months of continuation coverage if it is determined by the Social Security Administration that any covered family member is disabled at some time during the first 60 days of continuation coverage and which lasts at least until the end of the 18-month initial period of continuation coverage. Your Group Benefits Administrator must receive notification of the disability determination within 60 days of either 1. the date of the disability determination; 2. the date of the qualifying event; 3. the date on which coverage would be lost due to the qualifying event; or, 4. the date on which the qualified beneficiary is informed of the obligation to provide the disability

notice (e.g., through this General Notice), AND within the first 18 months of Extended Coverage. Notification must be presented in writing and include the following information:

- the name of the disabled qualified beneficiary;
- the date of the determination;
- documentation from the Social Security Administration to support the determination;
- the written signature of the notifying party (qualified beneficiary or representative);
- if the address of record is incorrect, a correct mailing address.

- **Second qualifying event extension of 18-month period of continuation coverage**
  If Your family experiences another qualifying event while receiving 18 months of Extended Coverage, the spouse and dependent children in Your family can get up to 18 additional months of continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given (in the format and time frame specified below) to Your Group Benefits Administrator. The extension may be available to the spouse and any dependent children receiving continuation coverage if the employee/former employee dies, the employee/former employee becomes divorced from the covered spouse, or the covered dependent child ceases to be eligible under the Plan, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. Written notification must be given within 60 days of the date coverage would have been lost due to the second qualifying event and should include the following information:
  - the type of second qualifying event (e.g., divorce, loss of dependent eligibility);
  - the name of the affected qualified beneficiary (e.g., spouse and/or dependent child);
  - the date of the second qualifying event;
  - documentation to support the occurrence of the second qualifying event (e.g., final divorce decree, dependent child's marriage certificate, proof of child's self-support);
  - the written signature of the notifying party;
  - if the address of record is incorrect, a correct mailing address.

  Failure to furnish timely and complete notification of the second qualifying event or disability determination will result in loss of additional Extended Coverage eligibility. Notice will be considered furnished when mailed or, in the case of hand delivery, the date it is received by Your Group Benefits Administrator.

  Separate guidelines apply to continuation coverage under the provisions of the Uniform Services Employment and Re-employment Rights Act of 1994 (USERRA). If these provisions apply to You, see Your Group Benefits Administrator for more information.

  If You Have Questions
  Questions concerning Your Plan or Your Extended Coverage rights should be addressed
  to the contacts listed below under "Plan Contact Information."

Keep Your Group Benefits Administrator Informed of Address Changes
In order to protect Your family's rights, You should keep Your Group Benefits Administrator informed of any changes in the addresses of family members. You should also keep a copy, for Your records, of any notices You send to Your Group Benefits Administrator.

The Plan Administrator Is:
The Department of Human Resource Management
101 N. 14th Street, 13th Floor
Richmond, Virginia 23219

Plan Contact Information
For information about Extended Coverage, initial notification of qualifying events, and initial enrollment, contact Your Group Benefits Administrator.
To makes changes to Extended Coverage after initial enrollment, contact Your Group Benefits Administrator.

Option to Purchase Individual Coverage when Group Coverage Ends
It may be possible for You to convert to non-group coverage once Extended Coverage ends. You must make application for coverage to health benefit companies that offer nongroup Plans within 31 days from the time Extended Coverage ends to prevent a lapse in coverage. If You have at least 18 months of creditable service as defined by HIPAA, You may have certain additional rights which may be exercised when securing individual coverage. Insurers that offer individual health Plans in the Commonwealth of Virginia must recognize creditable coverage so long as You have at least 18 months of creditable coverage and received Your most recent health coverage under an employer-related Plan.

10) Health Insurance Portability and Accountability Act (HIPAA) of 1996 and Certificate of Creditable Coverage
In the event that You leave this health Plan and go to a health Plan that includes a preexisting condition waiting period, You may be eligible for creditable coverage. The following list is considered creditable coverage and Your new health Plan may reduce the pre-existing condition waiting period by the amount of time, if any, You were covered by the following similar Plans:

- Medicare, Medicaid, Tricare, a medical care program of the Indian Health Service Program or a tribal organization, a Health Benefit Plan under the Peace Corps Act, a State health benefits risk pool, or any other similar publicly-sponsored program;
- a group Health Benefit Plan;
- a health Plan offered under Chapter 89 of Title 5, United States Code (5 U.S.C. Section 8901 et. Seq.);
- a public health Plan (as defined in federal regulations);
- Your current employer's eligibility waiting period;
- health insurance coverage consisting of benefits for medical care issued by an insurer, a health maintenance organization, a health service Plan, or a fraternal benefit society; or
- individual health insurance coverage.

If You should leave the Key Advantage Plan, Your Benefits Administrator will provide You with proof of prior coverage (certificate of coverage) for Your new health Plan if needed.

11) Plan Administrator's Continuing Rights
On occasion, the Plan Administrator or the State may not insist on Your strict performance of all terms of this Plan. Failure to apply terms or conditions does not mean the Plan Administrator or the State waives or gives up any future rights it may have. The Plan Administrator or the State may later require strict performance of these terms or conditions.

12) Time Limits on Legal Actions and Limitation on Damages

No action at law or suit in equity may be brought against the Plan Administrator, the State, or The Local Choice Group in any matter relating to (1) the Plan, (2) the Plan Administrator's performance or the State's performance under the Plan; or (3) any statements made by an employee, officer, or director of the Plan Administrator, the State, or The Local Choice Group concerning the Plan or the benefits available if the matter in dispute occurred more than one year ago.

In the event You or Your representative sues the Plan Administrator, the State, The Local Choice Group, or any director, officer, or employee of the Plan Administrator, the State, or The Local Choice Group acting in a capacity as a director, officer, or employee, Your damages will be limited to the amount of Your claim for covered services. The damages will not exceed the amount of any claim not properly paid as of the time the lawsuit is filed. In no event will this contract be interpreted so that punitive or indirect damages, legal fees, or damages for emotional distress or mental anguish are available.

13) Services After Amendment of This Plan

A change in this Plan will change covered services available to You on the Effective Date of the change. This means that Your coverage will change even though You are receiving covered services for an ongoing illness, injury, pregnancy-related condition, or if You may need more services or supplies in the future. There is only one exception. If You are an Inpatient on the day a change becomes effective, covered services Your Hospital provides You will not be changed for that admission. In this case, the change in Your coverage will be effective immediately after Your discharge for that admission.

14) Misrepresentation

A Participant's coverage can be canceled by the Plan Administrator, the State, or The Local Choice Group if it finds that any information needed to accept the Participant or process a claim was deliberately misrepresented by, or with the knowledge of, the Participant. The Plan Administrator, the State, or The Local Choice Group may also cancel coverage for any other family members enrolled with the Participant. When false or misleading information is discovered, the Plan Administrator, the State, or The Local Choice Group may cancel coverage retroactive to the date of misrepresentation.

15) Non-Payment of Monthly Charges

If You are required to pay monthly charges to maintain coverage, and such charges are late, the Plan Administrator has the right to suspend payment of Your claims. The Plan Administrator will not be responsible for claims for any period for which full monthly charges have not been paid. If Your monthly charges remain unpaid 31 days from the date due, the State or The Local Choice Group may instruct the Plan Administrator to cancel Your coverage.

16) Death of a Member

Coverage will end for a dependent enrolled with the Member if the Member dies unless continuation of coverage is properly elected and maintained pursuant to paragraph 9) of this section. Coverage for the dependent will end on the last day of the month in which the Member’s death occurs unless the local employer elects, in advance, a one month option for continued survivor coverage. If this option is elected, coverage for surviving dependents of a deceased member will continue until the end of the month following the date of the member’s death. Full premium, with continued employer and dependent

contribution, is required. Survivors must participate and no plan changes are permitted. The one month additional survivor benefit is a local employer option and must be elected annually by the local employer. The Local Choice Group will notify the Plan Administrator so that conversion privileges may be extended to the dependent.

17) Divorce

Coverage will end for the enrolled spouse of a Member on the last day of the month in which the final divorce decree is granted unless continuation of coverage is properly elected and maintained pursuant to paragraph 9) of this section. Conversion privileges for the spouse will be extended if the spouse notifies the Plan Administrator of the divorce in writing within 31 days after the end of the month in which the divorce is granted.

18) End of Dependent Coverage

When a dependent is no longer eligible for coverage, the dependent must notify the Plan Administrator in writing that he/she wishes to continue coverage under another contract or certificate rather than through The Local Choice Health Benefits Program. Conversion privileges for the dependent will be extended if the Plan Administrator receives notice within 31 days after the end of the month in which the dependent ceased to be eligible for coverage under The Local Choice Health Benefits Program.

19) Disclosure of Protected Health Information to the Employer

(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.

DEFINITIONS

Throughout this booklet are words which begin with capital letters. In most cases, these are defined terms. This section gives You the meaning of most of these words.

1) Allowable Charge
For care by a Physician or other health care professional, the Allowable Charge is the lesser of the Plan Administrator's allowance for that service, or the Provider's charge for that service.

For Hospital services, the Allowable Charge is the Plan Administrator's negotiated compensation to the facility for the covered service, or the facility's charge for that service, whichever is less.

For other services such as ambulance or home private duty nursing which are not considered Provider or facility services, the Allowable Charge is the amount the Plan Administrator determines to be reasonable for the services rendered.

For prescription drugs, the Allowable Charge is the lesser of the Plan Administrator's allowance for the prescription, or the cost of the drug.

2) Anesthesia Services
These are services to induce partial or complete loss of sensation before a Surgical Service or Maternity Service is performed.

3) Behavioral Health Services
These are services for the diagnosis and treatment of a Behavioral Health condition.

4) Clinical Trial Costs
Clinical Trial Cost means patient costs incurred during participation in a clinical trial when such a trial is conducted to study the effectiveness of a particular treatment of cancer where all of the following circumstances exist:

1) The treatment is being conducted in a Phase II, Phase III, or Phase IV clinical trial;

2) Treatment provided by a clinical trial is approved by:

- the National Cancer Institute (NCI);
- an NCI cooperative group or an NCI center;
- the U.S. Food and Drug Administration in the form of an investigational new drug application;
- the Federal Department of Veterans Affairs; or
- an institutional review board of an institution in the Commonwealth that has a multiple project assurance contract approved by the Office of Protection from Research Risks of the NCI;

3) With respect to the treatment provided by a clinical trial:

- there is no clearly superior, non-investigational treatment alternative;
- the available clinical or preclinical data provides a reasonable expectation that the treatment will be at least as effective as the non-investigational alternative; and

- the covered person and the Physician or health care Provider who provides the services to the covered person conclude that the covered person's participation in the clinical trial would be appropriate; and

4) The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and expertise.

"Patient cost" under this paragraph means the cost of a Medically Necessary health care service that is incurred as a result of the treatment being provided to the covered person for purposes of a clinical trial. "Patient cost" does not include (i) the cost of non-health care services that a patient may be required to receive as a result of the treatment being provided for purposes of a clinical trial, (ii) costs associated with managing the research associated with the clinical trial, or (iii) the cost of the investigational drug or device.

5) Coinsurance
This is the percentage of the Allowable Charge You pay for some covered services.

6) Copayment
This is the fixed dollar amount You pay for some covered services.

7) Cosmetic Surgery
Cosmetic Surgery is a Surgical Service performed mainly to improve a person's appearance. However, Cosmetic Surgery does not include Surgical Services to correct deformity resulting from disease, trauma, congenital abnormalities which cause functional impairment, or a previous therapeutic process. To determine if a Surgical Service is cosmetic or not, the Plan Administrator will not take into account the patient's mental state.

8) Deductible
This is a fixed dollar amount of covered services You pay in a Plan Year before Your Plan will pay for certain remaining covered services during that Plan Year. The Deductible amount is for a twelve month period from July 1 through June 30 and begins again each Plan Year. Deductible amounts incurred from April 1 through June 30 carry over to the new Plan Year.

9) Department
The Department denotes the Department of Human Resource Management (DHRM) and is the Commonwealth of Virginia's central source for information regarding The Local Choice Health Benefits Program.

10) Diagnostic Tests
This means the following procedures when ordered by Your doctor to diagnose a definite condition or disease because of specific signs and/or symptoms, including:
- laboratory and pathology services or tests;
- diagnostic EKGs, EEGs; and
- radiology (including mammograms), ultrasound or nuclear medicine;
- sleep studies.

Observation, diagnostic examinations, or diagnostic laboratory testing that involves a Hospital Stay is covered under Your Plan only when:
- Your medical condition requires that medical skills be constantly available;
- Your medical condition requires that medical supervision by Your doctor is constantly available; or
- diagnostic services and equipment are available only as an Inpatient.

11) Early Intervention Services

This phrase means Medically Necessary Speech and language therapy, Occupational Therapy, Physical Therapy and assistive technology services and devices for dependents from birth to age three who are certified by the Department of Mental Health, Mental Retardation, and Substance Abuse Services as eligible for services under Part H of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.). Medically Necessary Early Intervention Services for the population certified by the Department of Mental Health, Mental Retardation, and Substance Abuse Services means those services designed to help an individual attain or retain the capability to function age-appropriately within the individual's environment, and will include services which enhance functional ability without effecting a cure.

12) Effective Date

This is the date Your coverage begins under the Plan.

13) Emergency

This is the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity. This includes severe pain that without immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to result in:
- serious jeopardy to the mental and physical health of the individual;
- danger of serious impairment of the individual's body functions;
- serious dysfunction of any of the individual's bodily organs; or
- in the case of a pregnant woman, serious jeopardy to the health of the fetus.

14) Experimental/Investigative

Experimental/investigative means any service or supply that is judged to be experimental or investigative at the Plan Administrator's sole discretion. Services which do not meet each of the following criteria will be excluded from coverage as Experimental/Investigative:

1. Any supply or drug used must have received final approval to market by the U.S. Food and Drug Administration ("FDA") for the particular indication or application in question. Moreover, quantities of any drug or medication used must be within recommended maximum daily dose or duration established by the FDA or any of the standard reference compendia defined below. There are two exceptions which apply when a drug has received final approval to market by the FDA, but not for the particular indication or application in question.

    a) This criterion will be satisfied if the use of the drug is recognized for treatment of the indication or application in any of the following resources:

    - the following three standard reference compendia defined below:

        1) the U.S. Pharmacopoeia Dispensing Information

        2) the American Medical Association Drug Evaluations

        3) the American Hospital Formulary Service Drug Information

    - in substantially accepted peer-reviewed medical literature. Peer-reviewed medical literature means a scientific study published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts. This study must appear in a journal that has been

determined by the International Committee of Medical Journal Editors to have met the Uniform Requirements for Manuscripts submitted to biomedical journals. Peer-reviewed medical literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier; or

b) In the case where the drug is being used for the treatment of a specific type of cancer, this criterion will be satisfied if the use of the drug is recognized as safe and effective for treatment of the specific type of cancer in any of the standard reference compendia.

Despite the above two exceptions, this criterion will not be satisfied if the FDA has determined that use of the drug is not recommended for the treatment of the specific indication for which it is prescribed.

2. There must be enough information in the peer-reviewed medical and scientific literature to let us judge the safety and efficacy.

3. The available scientific evidence must show a good effect on health outcomes outside a research setting.

4. The service or supply must be as safe and effective outside a research setting as current diagnostic or therapeutic options.

New technologies are evaluated against these criteria to determine if services should be included as a covered benefit or considered Experimental/Investigative.

15) Health Benefit Plan

A Plan or program offering benefits for any type of health care service is considered a Health Benefit Plan when it is group or blanket insurance or a Blue Cross, Blue Shield, group practice, individual practice, or any other pre-payment arrangement (including this Plan) when an employer contributes any portion of the premium or an employer, association, or other group contracts for the coverage on Your behalf. A Plan or program offering benefits for any type of health care service is considered a Health Benefit Plan if it is provided in whole or in part by any labor management trustee Plan, union welfare Plan, employer organization Plan, or employee benefit organization Plan or by any governmental program or any coverage required or provided by law or statute.

The term Health Benefit Plan refers to each Plan or program separately. It also refers to any portion of a Plan or program which reserves the right to take into account benefits of other Health Benefit Plans when determining its own benefits. If a Health Benefit Plan has a coordination of benefits provision which applies to only part of its services, the terms of this section will be applied separately to that part and to any other part.

The term Health Benefit Plan as defined here does not include a prepaid health care services contract or accident and sickness policy which is individually underwritten, and individually issued, and provides only for accident and sickness benefits, and is paid for entirely by the Member.

16) Health Service Review

A health service review is a pre-service review (formerly known as preauthorization) that determines whether certain Outpatient services are covered under Your Plan and are Medically Necessary.

17) Hospital

a. This word means an institution which meets the American Hospital Association's standards for registration as a Hospital. It must be mainly involved in providing acute care for sick and injured Inpatients. The institution must be licensed as a Hospital by the State in which it operates.

   It must also have a staff of licensed Physicians and provide 24 hour nursing service by or under the supervision of Registered Nurses (R.N.s). Except in unusual cases approved in advance by the Plan Administrator, an institution will not be considered a Hospital if its average length of Stay is more than 30 days.

b. This word also means a facility providing Surgical Services to Outpatients. The facility must be licensed as an Outpatient Hospital by the state in which it operates. Inpatient services received from a facility of this type are not covered. Services provided by an Outpatient Hospital which is a Non-Network Hospital are not covered.

18) Inpatient

This term refers to a person who:

- is admitted to a Hospital or Skilled Nursing Facility;
- is confined to a bed there; and
- receives meals and other care in that facility.

19) Maternity Services

These are services for pregnancy or a pregnancy related condition.

20) Medical Services

These are services for the treatment of a medical condition. The term Medical services does not include Surgical Services, Maternity Services, Anesthesia Services, Behavioral Health Services, Diagnostic Tests, or Therapy Services.

21) Medically Necessary

To be considered Medically Necessary a service must be:

- required to identify or treat an illness, injury, or pregnancy-related condition:
- consistent with the symptoms or diagnosis and treatment of Your condition;
- in accordance with standards of generally accepted medical practice; and
- the most suitable supply or level of service that can safely treat the condition and not be the convenience of the patient, patient's family, or the Provider.

22) Medically Skilled Services

This is a service requiring the training and skills of a licensed medical professional. A service is not medically skilled simply because it is performed by medical professionals. If someone else can safely and adequately perform the service without direct supervision of a nurse or Provider, it will be classified as a non-Medically Skilled Service and will not be eligible for reimbursement.

23) Medicare

Medicare means the health insurance program established by Title XVIII of the Social Security Act of 1965, as amended.

24) Member

This word means the person who applies for coverage in the employee health benefits program and in whose name Your coverage is obtained.

25) Morbid Obesity

Morbid obesity means (i) a weight that is at least 100 pounds over or twice the ideal weight for frame, age, height, and gender as specified in the 1983 Metropolitan Life Insurance tables, (ii) a body mass index (BMI) 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 (iii) a BMI of 40 kilograms per meter squared without such comorbidity. As used herein, BMI equals weight in kilograms divided by height in meters squared.

26) Network and Non-Network Hospitals and Providers

A Network Hospital is a Hospital listed as a Network Hospital by the Plan Administrator. A Network Provider is a Provider listed as a Network Provider by the Plan Administrator. A Network Hospital or Network Provider must be listed as such at the time You receive the service for which coverage is sought. Any other Hospital or Provider is a Non-Network Hospital or Non-Network Provider.

The Plan Administrator may, at its sole option, name one or more Non-Network Hospitals as ones in which You will receive services as if You were in a Network Hospital. There is one difference. Payment will be made directly to the Member or, at the Plan Administrator's sole option, any other person responsible for paying the Non-Network Hospital's charge. The Member or other person responsible for paying the Non-Network Hospital’s charge will be responsible for sending payment to the Provider. The Member also will be responsible for the difference between the Plan's allowance and the Provider's charge. Payment by the Plan Administrator will relieve it and the Plan of any further liability for the Non-Network Provider's services.

These same definitions apply to all facility and professional Providers.

27) Network Schedule of Allowances

This term means the maximum allowances for services which are performed by Network Providers.

28) Other Covered Services (also formerly known as Major Medical Services)

These are services described in the Other Covered Services section and are subject to a Plan Year Deductible.

29) Out-of-Pocket Expense Limit

This is the amount of money You pay out of Your pocket for certain covered medical and behavioral health expense (combined) during the Plan Year. Once the limit is reached, almost all other covered expenses are paid in full (100% of the Allowable Charge) for the rest of the Plan Year. 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, and begins again each Plan Year. Copayments do not apply to the Out-of-Pocket Expense limit.

30) Outpatient

This term refers to a person who is not an Inpatient. An Outpatient is a person who receives care in a professional Provider's office, Hospital Outpatient department, Emergency room, or the home, for example.

31) Partial Hospitalization for Behavioral Health Services

Partial hospitalization combines intensive treatment in a medically supervised setting, with the opportunity for the patient to return home or to another residential setting at night. Care includes individual, group, family, educational, and rehabilitation services. These programs usually offer services three to five times per week for more than several hours per day.

32) Participant

This means the Member or eligible family members while enrolled in a Plan.

33) Physician

A Physician is a properly licensed doctor of medicine (M.D.)

34) Plan

Plan, in this booklet, means the Key Advantage Plan in which You are enrolled.

35) Plan Administrator

This word means the third party administrator under contract with the Department of Human Resource Management to develop and administer Provider networks, process claims, provide customer service, and such other functions as are necessary to make health benefits available to employees. Your Plan benefits are administered by four Plan Administrators: Anthem Blue Cross and Blue Shield for medical benefits; Delta Dental of Virginia for routine dental benefits, Medco Health Solutions, Inc. for prescription drugs; and ValueOptions, Inc. for Behavioral Health Services and the Employee Assistance Program (EAP).

36) Plan of Treatment

A Plan of Treatment is a program written by Your Provider. It describes Your condition and the services You need.

37) Plan Year

This is the period for which Plan benefits are administered, which is July 1 through June 30.

38) Primary Coverage

This means the Health Benefit Plan which will provide benefits first. It does not matter whether or not You have filed a claim for benefits with the primary Health Benefit Plan. If You are eligible for coverage under two Health Benefit Plans, the Primary Coverage will be used to decide what Secondary Coverage benefits are available.

39) Provider

The following are Providers who may give care under Your Plan:

- audiologists
- certified nurse midwives
- chiropractors
- chiropodists
- clinical social workers, psychologists, clinical nurse specialists in psychiatric behavioral health, professional counselors, marriage and family therapists
- dentists
- doctors of medicine (MD), including osteopaths and other specialists
- independent clinical reference laboratories

- occupational therapist
- opticians
- optometrists
- podiatrists
- registered physical therapists
- speech pathologists

40) Provider's Employee

A Provider's Employee is an allied health professional who works for the Provider. The Provider must withhold federal and State income and social security taxes from the Provider's Employee's salary. A Medical or Surgical Service which would have been covered if performed by Your Provider will be covered if performed by Your Provider's Employee, but only when:

- the Provider's Employee is licensed to perform the service;
- the service is performed under the direct supervision of Your Provider; and
- the services of the Provider's Employee are billed by Your Provider.

The services of the Provider's Employee are available as a substitute for the services of the Provider. For this reason, the Plan Administrator will not pay a supervisory or other fee for the same service rendered by both the Provider and the Provider's Employee.

41) Secondary Coverage

This is the Health Benefit Plan under which the benefits may be reduced to prevent duplicate or overlapping coverage.

42) Semi-Private Room

This phrase means a room with two, three, or four beds, all of which are used for Inpatient care.

43) Shots

These are injections that a Provider gives to treat illness or pregnancy-related conditions (e.g. allergy Shots). In addition, You have coverage for immunizations and self-administered injections. Some injections may be administered by a pharmacy that is authorized to perform this service. Contact the pharmacy to determine if they are authorized to do so.

44) Skilled Nursing Facility

A Skilled Nursing Facility is an institution licensed as a Skilled Nursing Facility by the state in which it operates. A Skilled Nursing Facility provides Medically Skilled Services to Inpatients. In most cases, the Inpatients require a lesser level of care than would be provided in a Hospital.

45) State

This word means the Commonwealth of Virginia.

46) Stay

This is the period from the admission to the date of discharge from a facility. All Hospital Stays less than 90 days apart are considered the same Stay, and a new Hospital Inpatient Copayment will not apply.

47) Surgical Services are:

- operative or cutting procedures for the treatment of an illness, injury, or pregnancy related condition;
- the treatment of fractures and dislocations; or
- endoscopic or diagnostic procedures such as cystoscopy, bronchoscopy, and angiocardiography.

48) The Local Choice Group

This means a local employer participating in The Local Choice Health Benefits Program.

49) The Local Choice Health Benefits Program

This means the health benefits program administered by the Department of Human Resource Management for the benefit of local governments, local officers, teachers, commissions, public authorities and other organizations created by or under an act of the General Assembly.

50) Therapy Services

Your Plan covers the following therapies when the treatment is Medically Necessary for Your condition and provided by a licensed therapist.

Cardiac Rehabilitation Therapy

This includes benefits for Cardiac Rehabilitation, which is the process of restoring and maintaining the physiological, psychological, social and vocational capabilities of patients with heart disease.

Chemotherapy

This covers the treatment of disease by chemical or biological antineoplastic agents.

Infusion Therapy

This is treatment by placing therapeutic agents into the vein, and parenteral administration of medication and nutrients. Infusion services also include enteral nutrition, which is the delivery of nutrients by tube into the gastrointestinal tract. These services include coverage of all medications administered intravenously and/or parenterally.

Occupational Therapy

This covers Occupational Therapy following disease, injury, or loss of limb. Occupational therapy is treatment to restore a physically disabled person's ability to perform activities such as walking, eating, drinking, dressing, toileting, transferring from wheelchair to bed, and bathing.

Physical Therapy

This covers Physical Therapy, which is treatment by physical means to relieve pain, restore function, and prevent disability following disease, injury, or loss of limb. Your coverage includes benefits for Physical Therapy to treat lymphedema.

Radiation Therapy

This covers Radiation Therapy, including the rental or cost of radioactive materials. It covers the treatment of disease by x-ray, radium, cobalt, or high energy particle sources.

Respiratory Therapy

This covers Respiratory Therapy, which is the introduction of dry or moist gases into the lungs to treat illness or injury.

Speech Therapy
This covers Speech Therapy, which is treatment for the correction of a speech impairment which results from disease, surgery, injury, congenital anatomical anomaly, or prior medical treatment. Speech therapy to treat development delay is not covered, except as required by § 2.2-2818 of the Code of Virginia for early intervention services.

51) Visit
This means a brief period during which You meet with a Physician or another person whose services are eligible for reimbursement.

52) Well Child Care
This term means services rendered for the routine care of a well child up to the date the child turns 7 years of age.

53) You, Your, or Yourself
These words refer to a Participant.

ELIGIBILITY

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 midyear 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, adoption, or placement for 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

* Placement, or being placed, for adoption means the assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child's adoption. The child's placement for adoption with such person ends upon the termination of such legal obligation. An agreement for full or partial support of a child will constitute a legal obligation. An agreement for full or partial support of a child will constitute a legal obligation only if the obligation is enforceable in a court of competent jurisdiction, which depends on the facts and circumstances associated with the agreement. The employee must be party to the support agreement and the agreement must extend beyond the obligation to provide medical coverage.

Additional Special Enrollment Rights
If You are eligible for health coverage, but not covered in a group health plan, there are two additional circumstances under the Health Insurance Portability and Accountability Act (HIPAA) that will permit You to enroll. You may enroll when:

- You or your dependent lose coverage in Medicaid or the State Children's Health Insurance Program (CHIP) and You request coverage under the plan within 60 days of the time your coverage ends; or
- You or your dependent become eligible for a Medicaid or CHIP premium assistance subsidy and You request coverage under the plan within 60 days after your eligibility is determined.

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

If You move in or out of Your plan's service area

You may change to another Plan or change membership if You move in or out of Your plan's service area. Submit Your Plan change within 31 days of the event. The change will be effective the first of the month after the submission is received.

Under HIPAA, if You lose Your group health Plan coverage, You may be able to get into another group health Plan for which You are eligible (such as a spouse's plan), even if the Plan generally does not accept late enrollees, if You request enrollment within 31 days.

Additionally, special enrollment rights are triggered by marriage, birth, adoption, and placement for adoption.

STATUTORY BENEFITS

Following is a list of benefits which must, by statute, be offered in The Local Choice Health Benefits Program. These may also be referred to as mandated benefits. The text below has been excerpted from the Code of Virginia, § 2.2-2818. This list will be updated each July 30. All of the statutory benefits are believed to have been incorporated into The Local Choice Health Benefits Program. Note: Where reference is made to State employees, this also refers to The Local Choice covered employees. The Local Choice Health Benefits Program and the State Health Benefits Program are governed by the same regulations.

Be it enacted by the General Assembly of Virginia:

1. That § 2.2-2818 of the Code of Virginia is amended and reenacted and that the Code of Virginia is amended by adding a section numbered 38.2-3407.13:2 as follows:

§ 2.2-2818. Health and related insurance for state employees.

A. The Department of Human Resource Management shall establish a plan, subject to the approval of the Governor, for providing health insurance coverage, including chiropractic treatment, hospitalization, medical, surgical and major medical coverage, for state employees and retired state employees with the Commonwealth paying the cost thereof to the extent of the coverage included in such plan. The same plan shall be offered to all part-time state employees, but the total cost shall be paid by such part-time employees. The Department of Human Resource Management shall administer this section. The plan chosen shall provide means whereby coverage for the families or dependents of state employees may be purchased. Except for part-time employees, the Commonwealth may pay all or a portion of the cost thereof, and for such portion as the Commonwealth does not pay, the employee, including a part-time employee, may purchase the coverage by paying the additional cost over the cost of coverage for an employee.

Such contribution shall be financed through appropriations provided by law.

B. The plan shall:

1. Include coverage for low-dose screening mammograms for determining the presence of occult breast cancer. Such coverage shall make available one screening mammogram to persons age 35 through 39, one such mammogram biennially to persons age 40 through 49, and one such mammogram annually to persons age 50 and over and may be limited to a benefit of $50 per mammogram subject to such dollar limits, deductibles, and coinsurance factors as are no less favorable than for physical illness generally.

The term "mammogram" shall mean an X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, film, and cassettes, with an average radiation exposure of less than one rad mid-breast, two views of each breast.

In order to be considered a screening mammogram for which coverage shall be made available under this section:

a. The mammogram shall be (i) ordered by a health care practitioner acting within the scope of his licensure and, in the case of an enrollee of a health maintenance organization, by the

health maintenance organization provider, (ii) performed by a registered technologist, (iii) interpreted by a qualified radiologist, and (iv) performed under the direction of a person licensed to practice medicine and surgery and certified by the American Board of Radiology or an equivalent examining body. A copy of the mammogram report shall be sent or delivered to the health care practitioner who ordered it;

b. The equipment used to perform the mammogram shall meet the standards set forth by the Virginia Department of Health in its radiation protection regulations; and

c. The mammography film shall be retained by the radiologic facility performing the examination in accordance with the American College of Radiology guidelines or state law.

2. Include coverage for the treatment of breast cancer by dose-intensive chemotherapy with autologous bone marrow transplants or stem cell support when performed at a clinical program authorized to provide such therapies as a part of clinical trials sponsored by the National Cancer Institute. For persons previously covered under the plan, there shall be no denial of coverage due to the existence of a preexisting condition.

3. Include coverage for postpartum services providing inpatient care and a home visit or visits that shall be in accordance with the medical criteria, outlined in the most current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists. Such coverage shall be provided incorporating any changes in such Guidelines or Standards within six months of the publication of such Guidelines or Standards or any official amendment thereto.

4. Include an appeals process for resolution of written complaints concerning denials or partial denials of claims that shall provide reasonable procedures for resolution of such written complaints and shall be published and disseminated to all covered state employees. The appeals process shall include a separate expedited emergency appeals procedure that shall provide resolution within one business day of receipt of a complaint concerning situations requiring immediate medical care. For appeals involving adverse decisions as defined in § 32.1-137.7, the Department shall contract with one or more impartial health entities to review such decisions. Impartial health entities may include medical peer review organizations and independent utilization review companies. The Department shall adopt regulations to assure that the impartial health entity conducting the reviews has adequate standards, credentials and experience for such review. The impartial health entity shall examine the final denial of claims to determine whether the decision is objective, clinically valid, and compatible with established principles of health care. The decision of the impartial health entity shall (i) be in writing, (ii) contain findings of fact as to the material issues in the case and the basis for those findings, and (iii) be final and binding if consistent with law and policy.

Prior to assigning an appeal to an impartial health entity, the Department shall verify that the impartial health entity conducting the review of a denial of claims has no relationship or association with (i) the covered employee, (ii) the treating health care provider, or any of its employees or affiliates, (iii) the medical care facility at which the covered service would be provided, or any of its employees or affiliates, or (iv) the development or manufacture of the drug, device, procedure or other therapy that is the subject of the final denial of a claim. The impartial health entity shall not be a subsidiary of, nor owned or controlled by, a health plan, a trade association of health plans, or a professional association of health care providers. There

shall be no liability on the part of and no cause of action shall arise against any officer or employee of an impartial health entity for any actions taken or not taken or statements made by such officer or employee in good faith in the performance of his powers and duties.

5. Include coverage for early intervention services. For purposes of this section, "early intervention services" means medically necessary speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices for dependents from birth to age three who are certified by the Department of Mental Health, Mental Retardation and Substance Abuse Services as eligible for services under Part H of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.). Medically necessary early intervention services for the population certified by the Department of Mental Health, Mental Retardation and Substance Abuse Services shall mean those services designed to help an individual attain or retain the capability to function age-appropriately within his environment, and shall include services that enhance functional ability without effecting a cure.

For persons previously covered under the plan, there shall be no denial of coverage due to the existence of a preexisting condition. The cost of early intervention services shall not be applied to any contractual provision limiting the total amount of coverage paid by the insurer to or on behalf of the insured during the insured's lifetime.

6. Include coverage for prescription drugs and devices approved by the United States Food and Drug Administration for use as contraceptives.

7. Not deny coverage for any drug approved by the United States Food and Drug Administration for use in the treatment of cancer on the basis that the drug has not been approved by the United States Food and Drug Administration for the treatment of the specific type of cancer for which the drug has been prescribed, if the drug has been recognized as safe and effective for treatment of that specific type of cancer in one of the standard reference compendia.

8. Not deny coverage for any drug prescribed to treat a covered indication so long as the drug has been approved by the United States Food and Drug Administration for at least one indication and the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.

9. Include coverage for equipment, supplies and outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes if prescribed by a healthcare professional legally authorized to prescribe such items under law. To qualify for coverage under this subdivision, diabetes outpatient self-management training and education shall be provided by a certified, registered or licensed health care professional.

10. Include coverage for reconstructive breast surgery. For purposes of this section, "reconstructive breast surgery" means surgery performed on and after July 1, 1998, (i) coincident with a mastectomy performed for breast cancer or (ii) following a mastectomy performed for breast cancer to reestablish symmetry between the two breasts. For persons previously covered under the plan, there shall be no denial of coverage due to preexisting conditions.

11. Include coverage for annual pap smears, including coverage, on and after July 1, 1999, for annual testing performed by any FDA-approved gynecologic cytology screening technologies.

12. Include coverage providing a minimum stay in the hospital of not less than 48 hours for a patient following a radical or modified radical mastectomy and 24 hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for treatment of breast cancer. Nothing in this subdivision shall be construed as requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate.

13. Include coverage (i) to persons age 50 and over and (ii) to persons age 40 and over who are at high risk for prostate cancer, according to the most recent published guidelines of the American Cancer Society, for one PSA test in a 12-month period and digital rectal examinations, all in accordance with American Cancer Society guidelines. For the purpose of this subdivision, "PSA testing" means the analysis of a blood sample to determine the level of prostate specific antigen.

14. Permit any individual covered under the plan direct access to the health care services of a participating specialist (i) authorized to provide services under the plan and (ii) selected by the covered individual. The plan shall have a procedure by which an individual who has an ongoing special condition may, after consultation with the primary care physician, receive a referral to a specialist for such condition who shall be responsible for and capable of providing and coordinating the individual's primary and specialty care related to the initial specialty care referral. If such an individual's care would most appropriately be coordinated by such a specialist, the plan shall refer the individual to a specialist. For the purposes of this subdivision, "special condition" means a condition or disease that is (i) life-threatening, degenerative, or disabling and (ii) requires specialized medical care over a prolonged period of time. Within the treatment period authorized by the referral, such specialist shall be permitted to treat the individual without a further referral from the individual's primary care provider and may authorize such referrals, procedures, tests, and other medical services related to the initial referral as the individual's primary care provider would otherwise be permitted to provide or authorize. The plan shall have a procedure by which an individual who has an ongoing special condition that requires ongoing care from a specialist may receive a standing referral to such specialist for the treatment of the special condition. If the primary care provider, in consultation with the plan and the specialist, if any, determines that such a standing referral is appropriate, the plan or issuer shall make such a referral to a specialist. Nothing contained herein shall prohibit the plan from requiring a participating specialist to provide written notification to the covered individual's primary care physician of any visit to such specialist. Such notification may include a description of the health care services rendered at the time of the visit.

15. Include provisions allowing employees to continue receiving health care services for a period of up to 90 days from the date of the primary care physician's notice of termination from any of the plan's provider panels. The plan shall notify any provider at least 90 days prior to the date of termination of the provider, except when the provider is terminated for cause.

For a period of at least 90 days from the date of the notice of a provider's termination from any of the plan's provider panels, except when a provider is terminated for cause, a provider shall be permitted by the plan to render health care services to any of the covered employees who (i) were in an active course of treatment from the provider prior to the notice of termination and (ii) request to continue receiving health care services from the provider.

Notwithstanding the provisions of subdivision 1, any provider shall be permitted by the plan to continue rendering health services to any covered employee who has entered the second trimester of pregnancy at the time of the provider's termination of participation, except when a

provider is terminated for cause. Such treatment shall, at the covered employee's option, continue through the provision of postpartum care directly related to the delivery.

Notwithstanding the provisions of subdivision 1, any provider shall be permitted to continue rendering health services to any covered employee who is determined to be terminally ill (as defined under § 1861 (dd) (3) (A) of the Social Security Act) at the time of a provider's termination of participation, except when a provider is terminated for cause. Such treatment shall, at the covered employee's option, continue for the remainder of the employee's life for care directly related to the treatment of the terminal illness.

A provider who continues to render health care services pursuant to this subdivision shall be reimbursed in accordance with the carrier's agreement with such provider existing immediately before the provider's termination of participation.

16. Include coverage for patient costs incurred during participation in clinical trials for treatment studies on cancer, including ovarian cancer trials.

The reimbursement for patient costs incurred during participation in clinical trials for treatment studies on cancer shall be determined in the same manner as reimbursement is determined for other medical and surgical procedures. Such coverage shall have durational limits, dollar limits, deductibles, copayments and coinsurance factors that are no less favorable than for physical illness generally.

For purposes of this subdivision:
"Cooperative group" means a formal network of facilities that collaborate on research projects and have an established NIH-approved peer review program operating within the group. "Cooperative group" includes (i) the National Cancer Institute Clinical Cooperative Group and (ii) the National Cancer Institute Community Clinical Oncology Program.
"FDA" means the Federal Food and Drug Administration.
"Multiple project assurance contract" means a contract between an institution and the federal Department of Health and Human Services that defines the relationship of the institution to the federal Department of Health and Human Services and sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects.
"NCI" means the National Cancer Institute.
"NIH" means the National Institutes of Health.
"Patient" means a person covered under the plan established pursuant to this section.
"Patient cost" means the cost of a medically necessary health care service that is incurred as a result of the treatment being provided to a patient for purposes of a clinical trial. "Patient cost" does not include (i) the cost of nonhealth care services that a patient may be required to receive as a result of the treatment being provided for purposes of a clinical trial, (ii) costs associated with managing the research associated with the clinical trial, or (iii) the cost of the investigational drug or device.

Coverage for patient costs incurred during clinical trials for treatment studies on cancer shall be provided if the treatment is being conducted in a Phase II, Phase III, or Phase IV clinical trial. Such treatment may, however, be provided on a case-by-case basis if the treatment is being provided in a Phase I clinical trial.

The treatment described in the previous paragraph shall be provided by a clinical trial approved by:
a. The National Cancer Institute;
b. An NCI cooperative group or an NCI center;

c. The FDA in the form of an investigational new drug application;
d. The federal Department of Veterans Affairs; or
e. An institutional review board of an institution in the Commonwealth that has a multiple project assurance contract approved by the Office of Protection from Research Risks of the NCI.

The facility and personnel providing the treatment shall be capable of doing so by virtue of their experience, training, and expertise.

Coverage under this section subdivision shall apply only if:

(1) There is no clearly superior, noninvestigational treatment alternative;

(2) The available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as effective as the noninvestigational alternative; and

(3) The patient and the physician or health care provider who provides services to the patient under the plan conclude that the patient's participation in the clinical trial would be appropriate, pursuant to procedures established by the plan.

17. Include coverage providing a minimum stay in the hospital of not less than 23 hours for a covered employee following a laparoscopy-assisted vaginal hysterectomy and 48 hours for a covered employee following a vaginal hysterectomy, as outlined in Milliman & Robertson's nationally recognized guidelines. Nothing in this subdivision shall be construed as requiring the provision of the total hours referenced when the attending physician, in consultation with the covered employee, determines that a shorter hospital stay is appropriate.

18. Include coverage for biologically based mental illness.

For purposes of this subdivision, a "biologically based mental illness " is any mental or nervous condition caused by a biological disorder of the brain that results in a clinically significant syndrome that substantially limits the person's functioning; specifically, the following diagnoses are defined as biologically based mental illness as they apply to adults and children: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder, obsessive-compulsive disorder, attention deficit hyperactivity disorder, autism, and drug and alcoholism addiction.

Coverage for biologically based mental illnesses shall neither be different nor separate from coverage for any other illness, condition or disorder for purposes of determining deductibles, benefit year or lifetime durational limits, benefit year or lifetime dollar limits, lifetime episodes or treatment limits, copayment and coinsurance factors, and benefit year maximum for deductibles and copayment and coinsurance factors.

Nothing shall preclude the undertaking of usual and customary procedures to determine the appropriateness of, and medical necessity for, treatment of biologically based mental illnesses under this option, provided that all such appropriateness and medical necessity determinations are made in the same manner as those determinations made for the treatment of any other illness, condition or disorder covered by such policy or contract.

In no case, however, shall coverage for mental disorders provided pursuant to this section be diminished or reduced below the coverage in effect for such disorders on January 1, 1999.

19. Offer and make available coverage for the treatment of morbid obesity through gastric bypass surgery or such other methods as may be recognized by the National Institutes of Health as effective for the long-term reversal of morbid obesity. Such coverage shall have durational limits, dollar limits, deductibles, copayments and coinsurance factors that are no less favorable than for physical illness generally. Access to surgery for morbid obesity shall not be restricted based upon dietary or any other criteria not approved by the National Institutes of Health. For purposes of this subdivision, "morbid obesity" means (i) a weight that is at least 100 pounds over or twice the ideal weight for frame, age, height, and gender as specified in the 1983 Metropolitan Life Insurance tables, (ii) a body mass index (BMI) 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 (iii) a BMI of 40 kilograms per meter squared without such comorbidity. As used herein, "BMI" equals weight in kilograms divided by height in meters squared.

20. Include coverage for colorectal cancer screening, specifically screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging, in accordance with the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations. The coverage for colorectal cancer screening shall not be more restrictive than or separate from coverage provided for any other illness, condition or disorder for purposes of determining deductibles, benefit year or lifetime durational limits, benefit year or lifetime dollar limits, lifetime episodes or treatment limits, copayment and coinsurance factors, and benefit year maximum for deductibles and copayments and coinsurance factors.

21. On and after July 1, 2002, require that a prescription benefit card, health insurance benefit card, or other technology that complies with the requirements set forth in § 38.2-3407.4:2 be issued to each employee provided coverage pursuant to this section, and shall upon any changes in the required data elements set forth in subsection A of § 38.2-3407.4:2, either reissue the card or provide employees covered under the plan such corrective information as may be required to electronically process a prescription claim.

22. Include coverage for infant hearing screenings and all necessary audiological examinations provided pursuant to § 32.1-64.1 using any technology approved by the United States Food and Drug Administration, and as recommended by the national Joint Committee on Infant Hearing in its most current position statement addressing early hearing detection and intervention programs. Such coverage shall include follow-up audiological examinations as recommended by a physician, nurse practitioner or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss.

C. Claims incurred during a fiscal year but not reported during that fiscal year shall be paid from such funds as shall be appropriated by law. Appropriations, premiums and other payments shall be deposited in the employee health insurance fund, from which payments for claims, premiums, cost containment programs and administrative expenses shall be withdrawn from time to time. The funds of the health insurance fund shall be deemed separate and independent trust funds, shall be segregated from all other funds of the Commonwealth, and shall be invested and administered solely in the interests of the employees and their beneficiaries. Neither the General Assembly nor any public officer, employee, or agency shall use or authorize the use of such trust funds for any purpose other than as provided in law for benefits, refunds, and administrative expenses, including but not limited to legislative oversight of the health insurance fund.

D. For the purposes of this section:
"Peer-reviewed medical literature" means a scientific study published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts in a journal that has been determined by the International Committee of Medical Journal Editors to have met the Uniform Requirements for Manuscripts submitted to biomedical journals. Peer-reviewed medical literature does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier.

"Standard reference compendia" means the American Medical Association Drug Evaluations, the American Hospital Formulary Service Drug Information, or the United States Pharmacopoeia Dispensing Information.

"State employee" means state employee as defined in § 51.1-124.3,; employee as defined in § 51.1-201,; the Governor, Lieutenant Governor and Attorney General,; judge as defined in § 51.1-301 and judges, clerks and deputy clerks of regional juvenile and domestic relations, county juvenile and domestic relations, and district courts of the Commonwealth,; and interns and residents employed by the School of Medicine and Hospital of the University of Virginia, and interns, residents, and employees of the Virginia Commonwealth University Health System Authority as provided in § 23-50.16:24.

"Part-time state employees" means classified or similarly situated employees in legislative, executive, judicial or independent agencies who are compensated on a salaried basis and work at least 20 hours, but less than 32 hours, per week.

E. Provisions shall be made for retired employees to obtain coverage under the above plan, including, as an option, coverage for vision and dental care. The Commonwealth may, but shall not be obligated to, pay all or any portion of the cost thereof.

F. Any self-insured group health insurance plan established by the Department of Human Resource Management that utilizes a network of preferred providers shall not exclude any physician solely on the basis of a reprimand or censure from the Board of Medicine, so long as the physician otherwise meets the plan criteria established by the Department.

G. The plan shall include, in each planning district, at least two health coverage options, each sponsored by unrelated entities. In each planning district that does not have an available health coverage alternative, the Department shall voluntarily enter into negotiations at any time with any health coverage provider who seeks to provide coverage under the plan. This section shall not apply to any state agency authorized by the Department to establish and administer its own health insurance coverage plan separate from the plan established by the Department.

H. Any self-insured group health insurance plan established by the Department of Personnel Human Resource Management that includes coverage for prescription drugs on an outpatient basis may apply a formulary to the prescription drug benefits provided by the plan if the formulary is developed, reviewed at least annually, and updated as necessary in consultation with and with the approval of a pharmacy and therapeutics committee, a majority of whose members are actively practicing licensed (i) pharmacists, (ii) physicians, and (iii) other health care providers.

If the plan maintains one or more drug formularies, the plan shall establish a process to allow a person to obtain, without additional cost-sharing beyond that provided for formulary prescription drugs in the plan, a specific, medically necessary nonformulary prescription drug if, after reasonable investigation and consultation with the prescriber, the formulary drug is

determined to be an inappropriate therapy for the medical condition of the person. The plan shall act on such requests within one business day of receipt of the request.

I. Any plan established in accordance with this section requiring preauthorization prior to rendering medical treatment shall have personnel available to provide authorization at all times when such preauthorization is required.

J. Any plan established in accordance with this section shall provide to all covered employees written notice of any benefit reductions during the contract period at least 30 days before such reductions become effective.

K. No contract between a provider and any plan established in accordance with this section shall include provisions that require a health care provider or health care provider group to deny covered services that such provider or group knows to be medically necessary and appropriate that are provided with respect to a covered employee with similar medical conditions.

L. The Department of Human Resource Management shall appoint an Ombudsman to promote and protect the interests of covered employees under any state employee's health plan. The Ombudsman shall:

1. Assist covered employees in understanding their rights and the processes available to them according to their state health plan.

2. Answer inquiries from covered employees by telephone and electronic mail.

3. Provide to covered employees information concerning the state health plans.

4. Develop information on the types of health plans available, including benefits and complaint procedures and appeals.

5. Make available, either separately or through an existing Internet web site utilized by the Department of Human Resource Management, information as set forth in subdivision 4 and such additional information as he deems appropriate.

6. Maintain data on inquiries received, the types of assistance requested, any actions taken and the disposition of each such matter.

7. Upon request, assist covered employees in using the procedures and processes available to them from their health plan, including all appeal procedures. Such assistance may require the review of health care records of a covered employee, which shall be done only with that employee's express written consent. The confidentiality of any such medical records shall be maintained in accordance with the confidentiality and disclosure laws of the Commonwealth.

8. Ensure that covered employees have access to the services provided by the Ombudsman and that the covered employees receive timely responses from the Ombudsman or his representatives to the inquiries.

9. Report annually on his activities to the standing committees of the General Assembly having jurisdiction over insurance and over health and the Joint Commission on Health Care by December 1 of each year.

M. The plan established in accordance with this section shall not refuse to accept or make reimbursement pursuant to an assignment of benefits made to a dentist or oral surgeon by a covered employee.

For purposes of this subsection, "assignment of benefits" means the transfer of dental care coverage reimbursement benefits or other rights under the plan. The assignment of benefits shall not be effective until the covered employee notifies the plan in writing of the assignment.

N. Any group health insurance plan established by the Department of Human Resource Management that contains a coordination of benefits provision shall provide written notification to any eligible employee as a prominent part of its enrollment materials that if such eligible employee is covered under another group accident and sickness insurance policy, group accident and sickness subscription contract, or group health care plan for health care services, that insurance policy, subscription contract or health care plan may have primary responsibility for the covered expenses of other family members enrolled with the eligible employee. Such written notification shall describe generally the conditions upon which the other coverage would be primary for dependent children enrolled under the eligible employee's coverage and the method by which the eligible enrollee may verify from the plan that coverage would have primary responsibility for the covered expenses of each family member.

O. Any plan established by the Department of Human Resource Management pursuant to this section shall provide that coverage under such plan for family members enrolled under a participating state employee's coverage shall continue for a period of at least 30 days following the death of such state employee.

P. The plan established in accordance with this section that follows a policy of sending its payment to the covered employee or covered family member for a claim for services received from a nonparticipating physician or osteopath shall (i) include language in the member handbook that notifies the covered employee of the responsibility to apply the plan payment to the claim from such nonparticipating provider, (ii) include this language with any such payment sent to the covered employee or covered family member, and (iii) include the name and any last known address of the nonparticipating provider on the explanation of benefits statement.

§ 38.2-3407.13:2. Claims paid to insureds for services from nonparticipating physicians.

When an insurer, health services plan or health maintenance organization follows a policy of sending its payment to the insured, subscriber or enrollee for a claim for services received from a nonparticipating physician or osteopath, the insurer, health services plan or health maintenance organization shall: (i) include language in the certificate or evidence of coverage of the insured, subscriber or enrollee that notifies the insured, subscriber or enrollee of the responsibility to apply the plan payment to the claim from such nonparticipating provider, (ii) include this language with any such payment sent to the insured, subscriber or enrollee, and (iii) include the name and any last known address of the nonparticipating provider on the explanation of benefits statement.

2. That the provisions of clause (iii) of § 38.2-3407.13:2 shall not become effective until January 1, 2006, as to any insurer, health services plan or health maintenance organization that as of January 1, 2005, had no more than 500,000 insureds, subscribers or enrollees in Virginia, including the Virginia enrollment of any affiliated insurer, health services plan or health maintenance organization.

OUTPATIENT MEDICATIONS THAT REQUIRE PRIOR AUTHORIZATION

Certain medications require prior authorization for coverage. In these cases, clinical criteria based on current medical information and appropriate use must be met. Information must be provided before coverage is approved. You, your doctor or your local pharmacist may call 1-800-753-2851 toll-free to initiate a coverage review. When use Medco by Mail, Medco will call you doctor to start the coverage review process. The prescription is reviewed with the doctor using clinical criteria based on common treatments, FDA approved prescribing and safety information, research and clinical guidelines used by doctors. Members with questions pertaining to prescription drug prior authorization should contact Medco Member Services at 1-800-355-8259 for more information.

Classification	Medications
Acne Therapy	Accutane, (Avita and Retin-A: greater than age 35)
Gastrointestinal Agent	Lotronex, Zelnorm
Growth Hormones	Geref, Geneotropin, Humatrope, Norditropin, Nutropin, Protropin, Saizen, Serostim, etc.
Intravenous Immunoglobulins	Gamimune N, Gammagard, Gammar-IV, Iveegam, Venoglobulin, Sandoglobulin
Interferons Actimmune	Alferon N, Intron A, Infergen, PEG Intron, Pegasys, Rebetron, Roferon-A
Gonadotropin Releasing Hormones/Analogs	Lupron, Synarel
Miscellaneous Agents	Weight-loss medications, Amevive, Botox, Gleevac, Lontronex, Myobloc, Provigil, Raptiva, Xolair, Zelmorn
NSAIDs/Cox-2 Inhibitors	Mobic, Celebrex
Respiratory Syncytial Virus Prevention	Synagis, Respigram
Rheumatoid Arthritis Therapy	Arava, Enbrel, Humira, Kineret, Remicade

MEDICATIONS WITH QUANTITY LIMITATIONS

The Plan has set quantity limitations for these drugs. You must obtain prior authorization to obtain quantities in excess of these limitations.

Medication	Quantity Limitation
Amerge	Any combination of tablets, not to exceed 12 per rolling 30 days
Axert	Any combination of tablets, not to exceed 12 per rolling 30 days
Caverject	Up to 8 injections per rolling 30 days
Cialis	Up to 8 tablets per 30 rolling days
Diflucan (150mg)	One tablet per prescription
Diflucan	Up to 7200mg in 180 days
Edex	Up to 8 injections per 30 rolling days
Frova	Any combination of tablets, not to exceed 12 per rolling 30 days
Imitrex	Any combination of tablets, injections or nasal spray, not to exceed 12 per rolling 30 days
Lamisil	Up to 22,500 mg within 180 days
Levitra	Up to 8 tablets per rolling 30 days
Maxalt	Any combination of tablets, not to exceed 12 per rolling 30 days
Muse	Up to 8 suppositories per rolling 30 days
Neulasta	One injections per copayment
Relenza	Up to 20 tabs in 180 days
Relpax	Any combination of tablets, not to exceed 12 per rolling 30 days
Sporanox	Up to 18,000mg within 180 days
Stadol Nasal Spray	Up to 4 canisters per rolling 30 days
Tamiflu	Up to 10 tabs within 180 days
Toradol	Up to 20 tablets or 20 injections per prescription
Viagra	Up to 8 tablets per rolling 30 days
Zomig	Any combination of tablets, not to exceed 12 per rolling 30 days

THIS LISTING IS SUBJECT TO CHANGE.

Revised 4/2005

The Local Choice
Certificate of Group Health Plan Coverage

Date of This Certificate: _____

Name of Participant: _____

Name of Health Care Plan: _____

Participant's Identification Number: _____

Membership Level (Single, Employee + One, Family): _____

Name of Individuals to Whom This Certificate Applies: _____

_____

Was the Period of Creditable Coverage More Than 18 Months? (Yes/No): _____

(Disregard periods of coverage before a 63-break.)

If Less Than 18 Months, Date Coverage Began: _____

Date Coverage Ended: _____

Date Waiting Period Began (If Applicable):_____

Person preparing this certificate and to whom questions should be addressed:

Name: _____

Address: _____

_____

Telephone No: _____E-mail Address: _____

Agency: _____

Note: Separate certificates will be furnished if information is not identical for the participant and each beneficiary.

Statement of HIPAA Portability Rights

This certificate is evidence of your coverage under the plan. You may need evidence of coverage to reduce a preexisting condition exclusion period under another plan, to help you get special enrollment in another plan, or to get certain types of individual health coverage even if you have health problems. This certificate, as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), is furnished to everyone leaving the State Health Benefits Program or the State Retiree Health Benefits Program (except for Medicare Supplement Plans). You may obtain additional certificates for you or your covered family members from your Agency Benefits Administrator (or the Virginia Retirement System for retirees) should you need them during the 24 months following your termination from the plan.

Pre-existing condition exclusions. Some group health plans restrict coverage for medical conditions present before an individual's enrollment. These restrictions are known as "pre-existing condition exclusions." A pre-existing condition exclusion can apply only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 months before your "enrollment date." Your enrollment date is your first day of coverage under the plan, or if there is a waiting period, the first day of your waiting period (typically, your first day of work). In addition, a pre-existing condition exclusion cannot last for more than 12 months after your enrollment date (18 months if you are a late enrollee). Finally, a pre-existing condition exclusion cannot apply to pregnancy and cannot apply to a child who is enrolled in health coverage within 30 days after birth, adoption, or placement for adoption.

If a plan imposes a pre-existing condition exclusion, the length of the exclusion must be reduced by the amount of your prior creditable coverage. Most health coverage is creditable coverage, including group health plan coverage, Extended Coverage (COBRA), coverage under an individual health policy,

Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), and coverage through high-risk pools and the Peace Corps. Not all forms of creditable coverage are required to provide certificates like this one. If you do not receive a certificate for past coverage, talk with your new Plan Administrator.

You can add up any creditable coverage you have, including the coverage shown on this certificate. However, if at any time you went for 63 days or more without any coverage (called a break in coverage) a plan may not have to count the coverage you had before the break.

- Therefore, once your coverage ends, you should try to obtain alternative coverage as soon as possible to avoid a 63-day break. You may use this certificate as evidence of your creditable coverage to reduce the length of any pre-existing condition exclusion if you enroll in another plan.

Right to get special enrollment in another plan. Under HIPAA, if you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. (Additionally, special enrollment rights are triggered by marriage, birth, adoption, and placement for adoption.)

- Therefore, once your coverage ends, if you are eligible for coverage in another plan (such as a spouse's plan), you should request special enrollment as soon as possible.

Prohibition against discrimination based on a health factor. Under HIPAA, a group health plan may not keep you (or your dependents) out of the plan based on anything related to your health. Also, a group health plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged a similarly situated individual.

Rights to individual health coverage. Under HIPAA, if you are an "eligible individual," you have a right to buy certain individual health policies (or in some states, to buy coverage through a high-risk pool) without a pre-existing condition exclusion. To be an eligible individual, you must meet the following requirements:

- You have had coverage for at least 18 months without a break in coverage of 63 days or more;
- Your most recent coverage was under a group health plan (which can be shown by this certificate);
- Your group coverage was not terminated because of fraud or nonpayment of premiums;
- You are not eligible for Extended Coverage (COBRA) or you have exhausted your Extended Coverage (COBRA) benefits; and
- You are not eligible for another group health plan, Medicare, or Medicaid, and do not have any other health insurance coverage.

The right to buy individual coverage is the same whether you are laid off, fired, or quit your job.

- Therefore, if you are interested in obtaining individual coverage and you meet the other criteria to be an eligible individual, you should apply for this coverage as soon as possible to avoid losing your eligible individual status due to a 63-day break.

For more information. If you have questions, you may contact the person who prepared this certificate. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) or the CMS publications hotline at 1-800-633-4227 (ask for "Protecting Your Health Insurance Coverage").

These publications and other useful information are also available on the Internet at **http://www.dol.gov/ebsa**, the U.S. Department of Labor's interactive web pages - Health Elaws, or **http://www.cms.hhs.gov/hipaa**.

Revised April 2005

The Local Choice
Request for Certificate of Group Health Plan Coverage

Use this form to request a Certificate of Group Health Plan Coverage from your Benefits Administrator. You may obtain additional certificates for you or your covered family members upon request while you are covered by the plan and during the 24 months following your termination from the plan.

Date of Request: _____

Name of Participant: _____

Address: _____

_____

Telephone Number: _____

E-mail Address: _____

Name and relationship of any dependents for whom certificates are requested (and their address if different from above):

_____

_____

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Revised April 2005

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