Anthem®

Short Option

Coverage for Short-Term Health Care Needs

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Short Option Health Coverage

We realize that many Virginians, for one reason or another, are in need of health care protection for just a short period of time. Short Option offers benefits similar to those available through our traditional major medical plans, but is designed especially for those in need of temporary protection. With Anthem's Short Option program, you don't have to worry about gaps in coverage while you're between health care plans.

Summary of Benefits

This chart lists benefits for each person on a policy. Because this policy offers coverage for a limited period of time, past or present health conditions are not covered. **All services require that you meet the deductible amount before receiving benefits.**

Lifetime Maximum	$1 Million
Providers	Freedom to choose doctors and hospitals; however, you save more on the cost of services by visiting a participating provider. See page 3 for details.
Policy Term	30, 60, 90 or 180 days
Benefit Period Deductible	$250, $500 or $1,000
Coinsurance	20% coinsurance
Out-of-Pocket Maximum	$1,000
Doctor Visits/Outpatient Services	20% coinsurance
Prescription Drugs	20% coinsurance
Emergency Services	20% coinsurance
Hospital Inpatient Services	20% coinsurance
Psychiatric & Chemical Dependency Care	**Outpatient:** first 5 visits at 20% coinsurance; visits 6-20 with a 50% coinsurance; **Inpatient:** 25 day Maximum with a 20% coinsurance

Important Terms

- **Allowable charge –** The allowance Anthem determines for covered services. Participating providers accept Anthem's allowable charge as payment in full.
- **Benefit Period –** The length of your coverage. This is the same as your policy term. For Short Option, it is either 30, 60, 90 or 180 days.
- **Coinsurance –** It's the percentage of the allowable charge that you pay.
- **Covered services –** A service or supply that we'll help cover, according to your policy, such as doctor's visits, diagnostic tests, hospitalization, prescription drugs, among others.
- **Deductible –** This is the amount you pay each benefit period for covered services before we start to share costs with you. The higher the deductible you choose, the lower your premium. The deductible is separate for each person. If there are three or more people on your policy, our family deductible can save you money. It is equal to two individual deductibles, so once the family amount is met, no one else on your policy has to meet a deductible for the rest of the benefit period.
- **Effective date –** The date your coverage begins.
- **Non-covered service –** Services we don't cover. Some examples are exercise equipment, stop-smoking programs, over-the-counter drugs, experimental treatment, whirlpool baths, private duty nursing, and transportation to and from the doctor.
- **Out-of-pocket expense limit –** Once you reach it, we cover almost 100% of your costs for the rest of the benefit period. You remain responsible for certain coinsurance amounts and other items that never count toward the out-of-pocket expense limit. (Please see page 6 for a list of these exceptions.)
- **Participating provider –** You get the protection and advantage of Anthem's "participating providers" to help save you money. These doctors agree to accept our allowable charge as payment in full for covered services. A "non-participating" doctor may charge more, and you are responsible for the difference. So, it's a good idea to make sure a doctor "participates" before you go. More than 90%* of doctors in Virginia participate with Anthem, giving you more choices and cost-saving options.
- **Pre-existing condition –** This policy never covers pre-existing conditions. A pre-existing condition is any medical condition you had in the 24 months before your policy's effective date. If you received medical advice, diagnosis, or care for a condition you had during that time, it is a pre-existing condition. A pre-existing condition is also a condition that would cause a prudent person to seek medical advice, diagnosis, care, or treatment. This means that if you had symptoms that would make an ordinary person seek treatment for the condition, that condition is a pre-existing condition, regardless of whether you went to the doctor for treatment. Prescription drugs prescribed for a pre-existing condition are not covered.

If you purchase two Short Option Policies with no break in coverage, medical conditions existing during the first policy will not be covered under the second policy.

* The Network Report, Anthem Blue Cross and Blue Shield, June, 2003.

You Should Know About...

Coordination of Benefits

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

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

Eligibility

Short Option is available only to those who:

- live or reside in the Anthem Blue Cross and Blue Shield service area for the term of the policy;
- are over the age of 3 months and under the age of 65;
- are not pregnant, are not the child of an expectant parent, or do not have a pregnant spouse/domestic partner or dependent child who is pregnant (even if not on the policy);
- are not entitled to Medicare benefits;
- are not eligible for Anthem group coverage;
- do not currently have individual protection that provides similar benefits, unless Short Option will replace the existing coverage;
- are United States citizens or who are foreign nationals who have lived in the United States for the two consecutive years prior to purchasing this coverage. This two year requirement is waived for foreign nationals who are on a valid and approved work or student VISA. The work or study program must be on a full-time basis. In addition, the foreign national may not travel outside the United States for more than 30 days during the term of the policy; and
- are not on active duty with any branch of the Armed Services.

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

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

Eligible children must also be:

- unmarried; and
- under age 19 (or under age 23 if a full-time student).

Your spouse/domestic partner and dependent children are eligible to apply for this coverage if they meet the above conditions.

Renewability

This policy is issued for a specified term (Benefit Period) for which you apply and are accepted. It cannot be renewed under any circumstances; however, you may purchase up to two Short Option policies in a calendar year. If you purchase two 180 day policies, you must have at least a 60 day break between the two.

Premium

We determine premiums based on such factors as age, sex, type and level of benefits and membership type. These premiums are set by class. You will not be singled out for a premium change. We will give you prior written notice of any premium change.

The premium must be included with your application. You can even pay by credit card. And the effective date can be as early as the day after we receive your completed application and payment. Your payment should be for the amount of the entire premium. However, if you are purchasing the 180 day coverage, you may pay half of the premium to begin your coverage, then you will be billed for the remaining premium.

Employer payment of premiums

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

Cancelling your policy

If you wish to cancel your Anthem policy, you must call or notify us in writing. Any premium paid beyond your cancellation date will be refunded to you within 31 days after the cancellation.

Termination

Termination of your policy will be effective as of 11:59 p.m. on the date of cancellation.

Exclusions and Limitations

In order for health care companies to cover a wide variety of services and keep the cost of health care coverage down for customers, most have exclusions and limitations. "Exclusions" are certain services or conditions that are not covered under a policy. "Limitations" are preset limits (or maximum amounts) for some services covered under a policy. If you have any questions, your Anthem Sales Representative is here to help.

Exclusions

This policy does not cover:

- Services and complications of services not specifically listed or described in the policy as covered services;
- Services for pre-existing conditions and related complications;
- Pregnancy-related services except complications of pregnancy related to a pregnancy beginning after the policy effective date;
- Services for artificial or surgical means of conception;
- Services for sickness or injury resulting from war or participation in a felony, riot, or any other act of civil disobedience;
- Services for injuries or sickness sustained while serving in any branch of the Armed Services;
- Travel or transportation, except professional ambulance services as described in the policy;
- All medical, surgical, and psychiatric services for or related to cosmetic surgery and/or cosmetic procedures, including any medical, surgical, and psychiatric services to correct complications of a person's cosmetic procedure. Body piercing and cosmetic tattooing are considered cosmetic procedures. "Cosmetic surgery," however, does not mean reconstructive surgery incidental to or following surgery caused by trauma, infection, or disease of the involved part. We determine, in our sole discretion, whether surgery is cosmetic or is clearly essential to the physical health of the patient.
- Services for palliative or cosmetic footcare.;
- Services covered under Federal or state programs (except Medicaid);
- Services performed by your immediate family or by you;
- Charges for telephone consultations or failure to keep scheduled appointments;
- Services rendered by a provider to a co-worker;
- Services for which a charge is not normally made;
- Separate charges for services by health care professionals employed by a Covered Facility which makes their services available;
- Services for any dental care, except as specifically provided for in the policy;
- Services for vision care except as stated in the policy;
- Inplantable or removable hearing aids, including exams for prescribing or fitting hearing aids regardless of the cause of the hearing loss, with the exception of cochlear implants;
- Services for rest cures, residential care or custodial care. Your coverage does not include benefits for care from a residential treatment center or other non-skilled, sub-acute setting, except to the extent such setting qualifies as a substance abuse treatment facility licensed to provide a continuous, structured, 24 hour-a-day program of drug or alcohol treatment and rehabilitation including 24 hour-a-day nursing care;
- Services for routine physical examinations, routine laboratory tests, routine x-rays, or other routine services that exceed what is specifically provided for in the policy;
- Services that are not Medically Necessary, in our sole discretion;
- Services for injuries or sickness resulting from any activities for wage or profit when 1) your employer makes payment to you because of your condition; 2) your employer is required by law to provide benefits to you; or 3) you could have received benefits for your condition if you had complied with the relevant law;
- Services we deem in our sole discretion to be Experimental/Investigative, except in certain limited circumstances as listed in the policy;
- Birth control devices or contraceptives;
- Therapy primarily for vocational rehabilitation;
- Certain services, including services for drug, alcohol or other psychiatric conditions rendered by any Skilled Nursing Facility or by any Home Health Care Agency;
- Certain drugs and therapeutic devices, including over-the-counter drugs and exercise equipment;
- Certain organ or tissue transplants that are considered experimental/investigative or not medically necessary;
- Outpatient services for marital counseling, coma-stimulation activities, and educational, vocational, and recreational therapy;
- Services performed outside the United States and its territories;
- Manual or mechanical interventions for illnesses or injuries other than musculoskeletal illnesses or injuries and any services over the first $500 paid;
- Self-help, training and self-administered services, including biofeedback and related testing;
- Vaccinations, immunizations, or other injections not used to treat a current illness, except as specifically provided for in the policy;

- Services for the following conditions (unless deemed emergency medical care): hernias, tonsil or adenoid disorders, reproductive organ disorders (excluding laparoscopy-assisted vaginal hysterectomy or vaginal hysterectomy), varicose veins and appendix disorders;
- Services for injuries or diseases resulting from any interscholastic sport; and
- Services or supplies ordered by a physician whose services are not covered under the policy.

Prescription Drugs

This policy does not cover:

- prescription drugs prescribed for pre-existing conditions;
- over-the-counter drugs;
- contraceptive pills;
- contraceptive devices (including contraceptive implants);
- charges to administer Prescription Drugs or insulin, except as stated in the Covered Services chapter;
- prescription refills that exceed the number of refills specified by the provider;
- a prescription that is dispensed more than one year after the order of a physician;
- drugs that are consumed or administered at the place where they are dispensed, except as stated in the Covered Services chapter;
- prescription drugs prescribed for weight loss or as stop-smoking aids;
- prescription drugs prescribed primarily for cosmetic purposes;
- prescription drugs dispensed by anyone other than a pharmacy, with the exception of a physician dispensing a one-time dosage of an oral medication either at the physician's office or in a covered outpatient setting in order to treat an acute situation; and
- prescription drugs not approved by the FDA.

Out-of-pocket expense limit exclusions

The following items never count toward your out-of-pocket expense limit:

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

Limitations

This policy covers certain services up to a preset limit. For example, visits to a health care provider may be limited by the number of visits, or services may be limited by a maximum dollar amount. Once you reach the preset limit on a service, the policy will not pay benefits for that service for the rest of the benefit period. Your policy will have detailed information on the benefit limitations that are outlined below.

Limitations under this policy are :

- psychiatric services: 20 visits for outpatient services; 25 days for inpatient services. Up to 10 inpatient days may be exchanged for 15 partial days. (1 inpatient day = 1.5 partial days.);
- manual or mechanical medical interventions, including spinal manipulation ($500 cap);
- outpatient physical therapy and/or outpatient occupational therapy ($1,000 cap);
- outpatient speech therapy ($250 cap);
- home health care services (45 visits);
- ground ambulance services ($1,500 cap);
- durable medical equipment ($2,500 cap).

Capped benefits are described in the policy. Please call your Anthem Sales Representative if you have any questions about any benefit we mention in this brochure.

Coinsurance Limitations

There are some coinsurance amounts you are always responsible for, even when you have met your deductible and out-of-pocket expense limit:

- coinsurance for outpatient psychiatric service visits;
- coinsurance for manual or mechanical medical interventions, including spinal manipulation;
- coinsurance for outpatient physical therapy, outpatient speech therapy and outpatient occupational therapy;
- coinsurance for durable medical equipment and home health care services; and
- coinsurance (which increases to 25%) for covered services received at non-participating hospitals or non-contracting substance abuse treatment facilities located in Virginia.

This is not your policy and is intended as a brief summary of services. If there is any difference between this brochure and the policy, the provisions of the policy shall control. This brochure is only one piece of your entire fulfillment kit. This brochure refers to Policy form # 900213 (PHC) 5/92, and Application # AVA1020.

Our service area is Virginia, excluding the city of Fairfax, the town of Vienna, and the area east of State Route 123.

Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Virginia, Inc.
An independent licensee of the Blue Cross and Blue Shield Association.
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Important Information About Your Personal Health Care Coverage

We recently changed the names of special services or clarified certain issues pertaining to your Anthem Blue Cross and Blue Shield health care coverage.

Unless otherwise noted, the following changes are effective as of July 1, 2007:

Pharmacy Name Change

In January 2007, our mail order pharmacy changed its name to WellPoint NextRx. The new name reflects Anthem's efforts to integrate our pharmacy companies and bring you quality service. While the name has changed, everything else remains the same, including your prescription drug benefits, phone numbers, web sites, hours of operation, current support resources, and the delivery of benefits and service.

Our mail service pharmacy is specifically designed for members who take maintenance medications on a regular basis for longer periods of time. This includes medications used to treat chronic conditions such as high cholesterol, diabetes, high blood pressure, arthritis, or depression, as well as medications used on a regular basis, such as oral contraceptives. You can learn more about our mail service pharmacy by visiting our Web site at:

Anthem.com > Members > Virginia >Plans and Benefits > Prescription >Mail Service Pharmacy

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Alcohol Exclusion Removed

We have removed the exclusion regarding alcohol, intoxicants and illegal substances from your health care contract. However, all other limitations and exclusions continue to apply. This change affects services for dates of service of July 1, 2007 and after.

New Application Form Numbers

Some of our application form numbers have changed. The new application form numbers are: AVA1647, AVA1628, AVA1631, AVA1663, AVA1648, AVA1629, AVA1632, AVA1664, AVA1649, AVA1630, AVA1633, AVA1665, AVA1634, AVA1635, and AVA1660.

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