Anthem BlueCross BlueShield

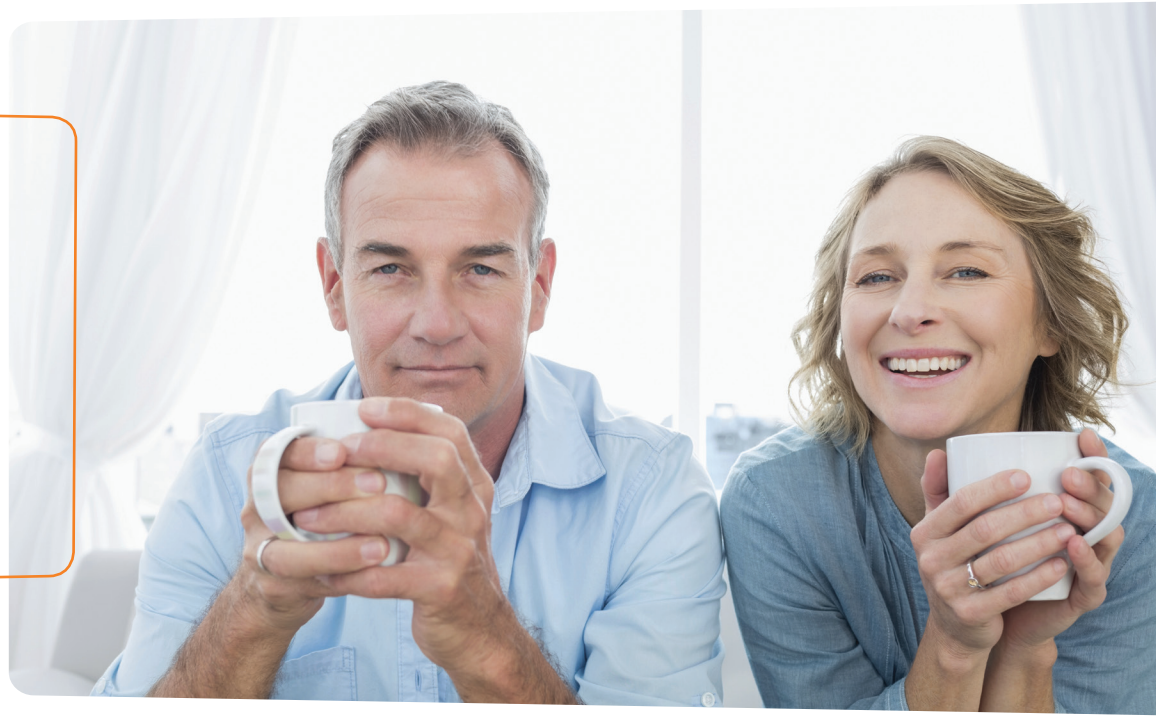
And Its Affiliate HealthKeepers, Inc.

VIRGINIA: Individual and Family

Your Health Plan Guide

Bronze, Silver, Gold and Catastrophic plans

Looking for a new health plan? We can help.



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Why Anthem HealthKeepers?

Health plans don't have to be complicated.

We understand that every individual and family is unique. That's why we offer many high-quality, affordable plan options for different health care needs and budgets. Our goal is not just to be there when you're sick, but also to help you stay well – at every stage of life.

With HealthKeepers, Inc. (HealthKeepers), you can count on:

- A strong network.
- Competitive pricing.
- A brand you can trust.
- Local presence where you live and work.
- Resources and support for your health care goals.
- Convenient online tools.
- A simple enrollment process.
- Dedicated customer service.
- All your benefits, including dental and vision, from one source.
- Coordinated care that connects your doctors and health care providers.

Check out our guide to learn about all that we offer, including health maintenance organization (HMO), point of service (POS), dental, vision and catastrophic plans. We're confident we can help find the right fit for you!

It's time to expect more of health care plans.

HealthKeepers is right there with you.

You want the best value your health care dollars can buy. And in Virginia, we deliver like no one else - through our networks and our experience.

48,176
PHYSICIANS[1]

106
HOSPITALS[1]

78 years
OF SERVICE[2]

[1] Based on Internal Provider Data Report, 2015. Medical doctors also includes Doctors of Osteopathic Medicine. Hospitals includes General Acute Care Hospitals; Surgical Services (Ambulatory Surgical Centers and Outpatient Hospitals) & Inpatient Psychiatry (Free-standing inpatient psychiatric facility and psychiatric beds within an Acute Care Hospital).
[2] Based on Internal Data, 2015.

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What we cover

All our plan options have one major goal — to help you stay healthy and find the quality coverage you need, when you need it. That's why, no matter which plan you choose, you're covered from preventive care to emergencies and everything in between!

Core benefits

Our plans include the essential health benefits (EHBs) mandated by the Affordable Care Act (ACA):

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services, like going to the emergency room (ER) or urgent care center, when medically necessary
- Hospitalization and inpatient services, such as surgery and the care you get when you stay overnight in a hospital
- Pregnancy, maternity and newborn care (care before and after your baby is born)
- Mental health and substance use disorder services, including behavioral health treatment (this includes counseling and psychotherapy)
- Prescription drug coverage
- Rehabilitative and habilitative services and devices (services and devices, like hospital beds, crutches, wheelchairs and oxygen tanks, to help people with injuries, disabilities or chronic health conditions gain or recover mental and physical skills)
- Laboratory and radiology services, including blood work, screenings and X-rays
- In-network preventive care services,[1] including wellness exams, immunizations, screenings and chronic disease management resources
- Pediatric dental coverage for children up to age 19, benefits include:[2]
  - Diagnostic and preventive services (cleaning, exams, X-rays)
  - Basic services (fillings)
  - Endodontic, periodontal and oral surgery
  - Medically necessary orthodontia
  - Access to any provider in the Dental Prime network
  - Shared deductible and out-of-pocket maximum with medical plan, and no annual maximum

Take care of yourself with no-cost, in-network preventive care

With HealthKeepers, you pay $0 out of pocket for covered in-network preventive services. So you can stay on top of your health care and your finances at no added cost![1]

- Pediatric vision coverage for children up to age 19, benefits include:
  - Yearly vision exams, glasses or contact lenses
  - Glasses with Transitions® lenses (to protect eyes from UV rays) and polycarbonate lenses and/or scratch coating (to protect lenses from damage) at no extra cost
  - Access to any provider in the Blue View Vision℠ network, with retailers such as 1-800-CONTACTS®, LensCrafters® and Target Optical®

[1] Nationally recommended preventive care services from in-network providers have no copay and no deductible requirement. Preventive and wellness services consist of certain services, including well-child care, immunizations, prostate-specific antigen (PSA) screenings, Pap tests, mammograms and more, recommended by the United States Preventive Services Task Force.

[2] If you choose a medical plan with out-of-network benefits, embedded dental benefits will also be available through out-of-network providers. If you choose a plan that only includes in-network benefits, the dental benefits will only be available through in-network providers. Remember, you save money when using in-network providers no matter which type of medical plan you choose.

Prescription drug benefits

Our prescription drug benefits help you cover the cost of your medications and get them to you in the most convenient way possible.

Here's what you need to know:

Select Drug List (formulary)

All our prescription drug plans have a formulary, a list of preferred generic and brand-name prescription drugs. This is called the Select Drug List. It includes the most commonly used Food and Drug Administration-approved drugs covered by your plan.

Prescription drug tiers

Every drug on the Select Drug List is assigned to a certain tier (or level) based on cost, the availability of over-the-counter alternatives, clinical information and other drugs in that class that may be used to treat the same or similar condition. The list tells you what tier your drug is in and details about its cost, which usually goes up the higher the drug tier. If your medication is in a higher tier, you may want to talk to your doctor about lower-cost options.

For more information about your prescription drug benefits, go to anthem.com:

- To find out if your medication is covered, check out our **VA Select Drug Tier 4** drug list at www.anthem.com/VASelectdrugtier4.
- To learn more about pharmacy processes and clinical edits, such as prior authorization, step therapy, quantity limits and dose optimization, visit
.
- To see if your pharmacy is in our network, select ***Find a Doctor***. Then, select Virginia and find the plan/network (Pathway Tiered Hospital) for the plan you're considering. Choose **Pharmacy** and the location.

We understand missing one dose of your maintenance medication can impact your health. Home delivery is a great way to make sure you get your refills when you need them. Plus, with home delivery, you can save on copays for 90-day supplies.*

Save with home delivery pharmacy

HealthKeepers wants to help lower the cost of your prescription drugs, improve your overall health and deliver top-notch customer service. We offer home delivery of your medicines right to your door.

If you take medicines for ongoing conditions like diabetes, high cholesterol and high blood pressure, you choose whether to use home delivery or continue with your retail pharmacy. **It's important to note, you'll need to let us know your choice before your third refill of any medicine at a retail pharmacy. If you don't choose, your prescriptions will no longer be covered until you notify us. So call as soon as possible.**

Using home delivery can help you save money. Depending on your plan, many 90-day supplies of generic medicines from home delivery cost the same as two 30-day supplies from a retail pharmacy. You could save up to four copays a year on one drug.* Plus, standard shipping is free!

* The home delivery pharmacy cost shares for Tier 1 drugs are 2 x the retail copay and for Tier 2 drugs are 2.5 x the retail copay when the plan has retail pharmacy copays.

Dental benefits

We offer a variety of Individual and Family dental plans to fit your health care needs and budget:

- Dental Prime[1]
- Anthem Dental Pediatric
- Anthem Dental Family and Anthem Dental Family Enhanced

You have the following options if you need or want to buy a medical plan that includes pediatric dental essential health benefits (EHB):

- A medical plan that has pediatric dental essential health benefits coverage
- A stand-alone pediatric dental essential health benefits policy (Dental pediatric plan)
- A stand-alone adult or family dental plan that includes pediatric dental essential health benefits coverage

Anthem Blue Cross and Blue Shield (Anthem) can help you get the dental care you need for better overall health. Many of our dental plans include 100% coverage for exams, cleanings and X-rays. Plus, there are benefits for fillings, crowns, root canals, oral surgery and orthodontia. To see more detailed benefits, go to the **Dental stand-alone plans benefit chart** section.

Vision benefits

We also offer a Blue View Vision℠ plan, which you can add on to any HealthKeepers medical and/or Anthem dental plan.

With Blue View Vision, you can get your eye care and eyewear just about anywhere! Our large national vision network gives you:

- Over 33,000 eye doctors[2] at more than 26,000 locations to choose from — so you're sure to find an eye care professional that's close to home or work.
- Access to 1-800 CONTACTS online or by phone, private practice eye doctors, and in-store visits to LensCrafters®, Sears Optical℠, Target Optical®, JCPenney® Optical and most Pearle Vision® locations.

The medical + dental + vision advantage
Coordinating medical, dental and vision plans can result in better care — delivered sooner and at a lower cost. Plus, you enjoy the convenience of having only one ID card and one bill when you purchase all your coverage from Anthem.

Blue View Vision coverage includes:

- Eye exams once every 12 months
- Standard lenses (single vision, bifocal and trifocal) once every 24 months
- Contact lenses (conventional and disposable) once every 24 months
- Frames once every 24 months
- Lots of additional discounts and benefits[3]

[1] Does not include ACA required pediatric dental essential health benefits coverage.
[2] Blue View Vision internal data, 2015.
[3] Discounts referenced are not covered benefits under the vision plan and are not included in the Evidence of Coverage. Laws in some states may prohibit in-network providers from discounting products and services that are not covered benefits under the plan. Discounts are subject to change without notice.

How to choose a plan

Figuring out what you need

Choosing the right health care plan can be challenging. To help you pick, consider the questions below. And remember, your HealthKeepers authorized sales representative is here to provide answers and give advice.

Things to think about:

- **Does the plan meet your likely coverage needs?** How often do you see doctors and specialists? What prescription medications do you take regularly? Are you planning any procedures this year?
- **Is staying with your current doctor(s) important?** If the answer is yes, then you can use our **Find a Doctor** tool at anthem.com to check that your doctor is in our network. If you choose a POS plan and your doctor is not in the network, you'll still have coverage; however, you have to decide whether you want to pay higher out-of-network cost shares. If you buy an HMO plan, you'll only have out-of-network benefits for medically necessary emergency care, urgent care and ambulance services. For all other out-of-network services, you'll pay the full cost for services. Sticking with in-network doctors will save you a lot of money.
- **What is your family's budget?** You may prefer to pay more monthly in premiums and less out of pocket for services, like doctor visits or lab work. Or you may want to pay higher out-of pocket costs for services in exchange for a lower fixed — and predictable — monthly premium. It depends on how well you think your budget can handle the unexpected. Our plans offer different deductible, coinsurance and copay options, so you can find the level of cost sharing that works for you.
- **Is a Catastrophic plan an option?** If you're under age 30 or are 30 years of age or older with an approved hardship exemption from the Health Insurance Marketplace, you may qualify for a high deductible, low premium, Catastrophic plan. Catastrophic plans can help protect you from worst-case scenarios like serious accidents or illnesses.

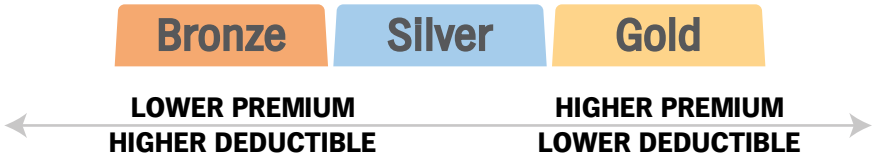
Consider a health savings account (HSA)

Contributing to an HSA can help your money go further. An HSA is a savings account you can open when you have a qualified high-deductible health plan (HDHP). You set up the account through a bank and fund it with post-tax dollars. That money can be used to pay for health care expenses, including prescriptions. Plus, you can claim your HSA contributions as tax deductions even if you don't itemize them on Form 1040. HSA-compatible health care plans work with or without this savings account; the choice is yours.

Our HSA-compatible plans include HSA in the plan name. Check with your tax advisor to see if an HSA plan is right for you. You can also learn more about HSAs from the HSA flier included with this brochure.

What are your plan choices?

Plan Levels



How your plan might work

With most health care plans, you pay a monthly fee called a premium; then, you share some of the cost of care with your health insurance company. **With HealthKeepers, you choose the level of cost sharing that works for you.**

Here's an example: *Meet John**

To show you how your health plan might work, we'd like to introduce you to "John." The cost-share amounts used in this example may not apply to the plan you're interested in. Be sure to look at the actual benefits for each plan when you're deciding.

John's story

After injuring his knee in a soccer game, John calls his doctor. He chooses a provider in our network, which saves him the most money. John gets HealthKeepers negotiated rates because he uses in-network providers. **Below, see how John's benefits work, his treatment costs and why it's important to have health insurance:***

John's health plan has the following benefits:

- $2,000 deductible
- 30% coinsurance
- $5,000 out-of-pocket limit
- $35 copay for doctor visits

Copay
On some plans, you pay a fixed-dollar amount or copay for certain services. For example, you may have a $35 copay for in-network doctor visits.

Let's take a closer look at John's doctor visit:

- *Doctor visit cost (without insurance):* $200
- *HealthKeepers' negotiated rate:* $140
- *HealthKeepers pays:* $105
- ***John paid:* $35** (This is his plan's copay for doctor office visits.)

Deductible
You pay this amount for covered medical services each calendar year, from January 1 through December 31. Your deductible starts over each calendar year.

Covered services that apply to the deductible include lab work, X-rays, anesthesia and surgeon fees. Covered in-network preventive services have no deductible, coinsurance or copay.

Here's what happens when John's doctor orders an approved magnetic resonance imaging (MRI) of the knee and recommends surgery:

MRI

- *MRI cost (without insurance):* $1,500
- *HealthKeepers' negotiated rate:* $1,000
- ***John paid:* $1,000** (John's payment counts toward his plan's $2,000 deductible.)

Surgery

- *Hospital/surgery costs (without insurance):* $50,000
- *HealthKeepers' negotiated rate:* $35,000
- ***John paid:* $1,000** (John's payment satisfies the remaining $1,000 deductible.)
- *Remaining cost of surgery:* $34,000

* While the characters in this example are not real, and the situation is hypothetical, the clinical aspects are accurate and realistic.

Coinsurance Once you've met your deductible, HealthKeepers starts paying a portion of your claims. Then, you and HealthKeepers share responsibility for your health care bills. Your coinsurance is the percentage that you must pay for a covered service each calendar year. Having met his deductible, John's coinsurance begins.	**Let's check in to see John's final costs:** • *Coinsurance:* .....30% (30% of $34,000 = $10,200) ▶ ***John paid:* $2,965** (John's payment satisfies the remainder of his $5,000 out-of-pocket limit.)
Out-of-pocket limit This is the most you pay during a calendar year. Your combined deductible, coinsurance and copay costs typically make up your out-of-pocket limit. Once you meet this limit, your health insurance covers 100% (of the maximum allowed amount) of covered services for the rest of the calendar year.	**John has met his out-of-pocket limit and the remaining surgery costs are paid by HealthKeepers:** • *HealthKeepers pays:* .....$31,035 • *John's out-of-pocket limit:* $5,000
Summary John paid far less out of pocket because he had health care coverage and stayed in our network. If John had used a doctor outside our network, he would have paid more. Keep in mind if your plan doesn't include coverage for out-of-network benefits, you'll pay the full cost for services from out-of-network providers with the exception of medically necessary emergency and urgent care.	• *Total for the doctor visit, MRI and surgery (without health insurance):* .....$51,700 • *Total HealthKeepers paid after discounts:* .....$31,140 ▶ ***Total John paid:* .....$5,000** ($35 office visit + $2,000 deductible + $2,965 coinsurance = $5,000)

Call your HealthKeepers authorized sales representative for more information.

You can also visit our website, **anthem.com**, to view and compare different plans. To get started, choose **Shop for Insurance** in the top menu and follow the instructions.

* While the characters in this example are not real, and the situation is hypothetical, the clinical aspects are accurate and realistic.

Do you qualify for financial help?

With the Affordable Care Act (ACA), you have to get health care coverage unless you qualify for an exemption. But you may be eligible for financial help to pay for your insurance. This help would be in the form of tax credits toward your monthly premium on all plans or cost-sharing subsidies on Silver plans when you buy a plan on the Health Insurance Marketplace. The amount and type of financial aid you receive is based on your income, family size and where you live. **Catastrophic plans are not eligible for tax credits**.

How do you know if you qualify for a tax credit or cost-sharing subsidy?

Before you choose a plan, it's a good idea to find out if you qualify to get help paying for your health insurance. Check with your HealthKeepers authorized sales representative for more information and to find out if you qualify for a tax credit or cost-sharing subsidy.

If you do qualify, it may make more sense for you to choose an Anthem HealthKeepers plan available through the Health Insurance Marketplace. If you don't qualify for a tax credit or cost-sharing subsidy or if you're shopping for a dental or vision plan, you don't have to buy through the Health Insurance Marketplace. You may find it easier to purchase your plan directly from HealthKeepers.

Whether you choose an Anthem HealthKeepers plan offered through the Health Insurance Marketplace or direct through HealthKeepers, we have great plan options for you.

You may be eligible for financial help on your coverage.

To find out, go to www.healthcare.gov. Select **Get Answers**. Then, **Getting lower costs** under *Get Coverage*.

Avoid tax penalties

When you put off enrolling in a health plan, you may have to pay a penalty – unless you qualify for an exemption. Penalties are based on your income and increase each year for inflation. To learn how tax penalties could effect you, contact a tax advisor.

Overview of plans and networks

Network choices

What is a network?

When you need care, you'll get the best value by visiting contracted **in-network** doctors, hospitals or other health care providers. HealthKeepers has negotiated discounted rates for covered services with these **in-network** providers to save you money. Since we can't control what **out-of-network** providers charge, if you choose to go outside of our network, you'll pay more out of pocket with POS plans and you'll pay 100% out of pocket with HMO plans.

A network includes:

- Doctors, therapists, mental health providers and other health care professionals
- Hospitals and outpatient facilities
- Pharmacies
- ERs and urgent care centers
- Labs and radiology centers
- Durable medical equipment, like hospital beds, crutches, wheelchairs and oxygen tanks (retail and online stores)

Types of plans: HMO and POS

Depending on what type of plan you choose, your benefits and provider choices may be different. With our plans, you have the freedom to see any in-network doctor you choose without a referral. It's also a good idea to have a primary care doctor to coordinate your care, but you're not required to pick one.

- **HMO:** Our HMO plans don't offer out-of-network benefits, except for emergency and urgent care or when a service is preauthorized. If you go outside the network for any other reason, you'll have to pay 100% out of pocket.
- **POS:** With our POS plans, you can go out of network, but you'll pay a higher deductible, copay or coinsurance. Plans with out-of-network benefits have "POS" in the plan name. POS plans are available in certain regions within our service area. Please refer to the **Medical plan benefit charts** for more information.
- **Tiered hospitals:** Our network includes tiered hospitals. Hospitals are split into two categories: Tier 1 and Tier 2. You pay a lower cost share for hospitals in Tier 1. To see what tier a hospital is in, visit the **Find a Doctor** tool at anthem.com.

How do I know if a provider is in the network?

To check, use our ***Find a Doctor*** tool – it's quick and easy! Go to anthem.com and select **Find a Doctor**. Then, select Virginia and find the plan/network **(Pathway Tiered Hospital)** you're considering. Choose what you're looking for (in-network doctors, specialists, hospitals (Tier 1 and Tier 2) or urgent care centers) and the location. You'll get a list of providers, including detailed information about them like location, gender, specialty, certifications, availability and much more. Network availability may depend on where you live.

For searches on the go, download our **anthem.com** mobile app to your mobile device.

Reading our benefit charts

Take a look at the following charts to see explanations of some common benefits, such as deductibles, out-of-pocket limits and coinsurance amounts, for each plan level. **The benefit information shown is for *in-network* services only, unless otherwise noted.**

For more information, contact your HealthKeepers authorized sales representative. You can also view and compare plans on anthem.com. To get started, choose **Shop for Insurance** in the top menu and follow the instructions.

Here's a quick look at how to read our plan benefit charts.[1]

	Anthem HealthKeepers Bronze 4650/35% (1GB9)
Network Name	Pathway Tiered Hospital
Plan includes out-of-network coverage?	No
Individual Deductible	$4,650
Individual Out-of-Pocket Limit	$6,850
Coinsurance	35% coinsurance
Office Visit: Primary Care Physician (PCP) *NOTE: Other office services may be subject to a deductible and plan coinsurance*	$45 copay per visit for first 3 office visits, then deductible and 35% coinsurance
Office Visit: Specialist	
Outpatient Diagnostic Tests	
Outpatient Advanced Diagnostic Tests	
Urgent Care	
Emergency Room Care	
Hospital: Inpatient Admission	
Hospital: Outpatient Facility	
Retail Pharmacy Deductible	
Retail Pharmacy Tier 1/Tier 2	
Retail Pharmacy Tier 3/Tier 4	
Dental and Vision	

- Indicates the plan name and contract code. Look for this when you're applying for a plan. The contract code is in parentheses after the plan name.
- Indicates the plan's network. Use the ***Find a Doctor*** tool at anthem.com to see if your doctor is in the network.
- Indicates whether the plan includes coverage for out-of-network benefits. **In-network** refers to providers who are part of the plan's network. **Out-of-network** refers to providers who don't participate in the network.
- The **deductible** is a set amount that you pay out of pocket before your plan starts paying for covered services, except for in-network preventive services.[2] ***For example:*** If your deductible is $4,650, your plan won't pay anything until you've met your $4,650 deductible for covered health care services. Some plans may cover certain services, such as doctor office visits, before you meet the deductible.

  Our plans have embedded family deductibles, where each covered family member only needs to satisfy his or her individual deductible, not the entire family deductible, before receiving plan benefits. No one family member pays more than the individual deductible.

  The chart displays the individual deductible. Family deductibles are two (2) x the individual amount.

  Note: You must meet your deductible every calendar year (January 1 through December 31), even if your effective date (the date your coverage begins) is later than January 1.

[1] The cost-share amounts used in this example may not apply to the plan you're interested in. Be sure to look at the actual benefits for each plan when you're deciding.

[2] Nationally recommended preventive care services from in-network providers have no copay and no deductible requirement. Preventive and wellness services consist of certain services, including well-child care, immunizations, prostate-specific antigen (PSA) screenings, Pap tests, mammograms and more, recommended by the United States Preventive Services Task Force.

	Anthem HealthKeepers Bronze 4650/35% (1GB9)
Network Name	Pathway Tiered Hospital
Plan includes out-of-network coverage?	No
Individual Deductible	$4,650
Individual Out-of-Pocket Limit	$6,850
Coinsurance	35% coinsurance
Office Visit: Primary Care Physician (PCP) *NOTE: Other office services may be subject to a deductible and plan coinsurance*	$45 copay per visit for first 3 office visits, then deductible and 35% coinsurance
Office Visit: Specialist	
Outpatient Diagnostic Tests	
Outpatient Advanced Diagnostic Tests	
Urgent Care	
Emergency Room Care	
Hospital: Inpatient Admission	
Hospital: Outpatient Facility	
Retail Pharmacy Deductible	
Retail Pharmacy Tier 1/Tier 2	
Retail Pharmacy Tier 3/Tier 4	
Dental and Vision	

The **out-of-pocket limit** is the most you pay during a policy period (each calendar year) before your health insurance or plan begins to pay 100% of the maximum allowed amount. ***For example:*** If your out-of-pocket limit is $6,850, you'll continue to pay your coinsurance and copays, if applicable, until you've met your $6,850 out-of-pocket limit. Once you have met your out-of-pocket limit, your plan begins to pay 100% of the maximum allowed amount during that calendar year.

This limit never includes your premium, balance-billed charges or services your plan doesn't cover. The amount includes deductible, copays, coinsurance and pharmacy costs. Our plans have embedded family out-of-pocket limits where each covered family member only needs to satisfy his or her individual out-of-pocket limit, not the entire family out-of-pocket limit, before the plan pays 100% of the maximum allowed amount for services.

The chart displays the individual out-of-pocket limit. Family out-of-pocket limits are two (2) x the individual amount.

Coinsurance is the amount you pay for health care services. It's a certain percentage of the cost of services after the deductible has been paid. ***For example:*** A health plan pays 65% of the maximum allowed amount for a service and you pay the remaining 35% or coinsurance.

A **copay** is a fixed fee that you pay out of pocket for each visit to a health care provider. ***For example:*** If your copay is $45, then you pay $45 when you see your doctor — usually at the time you receive treatment. The amount of your copay may depend on the type of health care service you receive.

In-network preventive care is covered at no cost to you![2]

[1] The cost-share amounts used in this example may not apply to the plan you're interested in. Be sure to look at the actual benefits for each plan when you're deciding.

[2] Nationally recommended preventive care services from in-network providers have no copay and no deductible requirement. Preventive and wellness services consist of certain services, including well-child care, immunizations, prostate-specific antigen (PSA) screenings, Pap tests, mammograms and more, recommended by the United States Preventive Services Task Force.

Medical plans benefit charts

	Anthem HealthKeepers Bronze 35% for HSA (1GBB)	Anthem HealthKeepers Bronze POS 4100/30% (1GBA)	Anthem HealthKeepers Bronze 4650/35% (1GB9)
Network Name[1]	Pathway Tiered Hospital	Pathway Tiered Hospital	Pathway Tiered Hospital
Plan includes out-of-network coverage?[1]	No	Yes	No
Individual Deductible[2]	$4,000	$4,100 / $8,200 In-network / Out-of-network	$4,650
Individual Out-of-pocket Limit[2]	$6,550	$6,850 / $15,000 In-network / Out-of-network	$6,850
Coinsurance[2]	35% coinsurance	30% / 30% coinsurance In-network / Out-of-network	35% coinsurance
Office Visit: Primary Care Physician (PCP)[3] NOTE: Other office services subject to deductible and plan coinsurance.	Deductible, then 35% coinsurance	$35 copay per visit for first 5 office visits, then deductible and 30% coinsurance (Visit limits for PCP and Specialist are combined.)	$45 copay per visit for first 3 office visits, then deductible and 35% coinsurance
Office Visit: Specialist	Deductible, then 35% coinsurance	$65 copay per visit for first 5 office visits, then deductible and 30% coinsurance (Visit limits for PCP and Specialist are combined.)	Deductible, then 35% coinsurance
Outpatient Diagnostic (Ex. X-ray, Lab) **and Outpatient Advanced Diagnostic Tests** (Ex. MRI, CT scan)[4]	Deductible, then 35% (tier 1) / 50% (tier 2) coinsurance	Deductible, then 30% (tier 1) / 50% (tier 2) coinsurance	Deductible, then 35% (tier 1) / 50% (tier 2) coinsurance
Urgent Care	Deductible, then 35% coinsurance	Deductible, then 30% coinsurance	Deductible, then 35% coinsurance
Emergency Room Care	Deductible, then 50% coinsurance	Deductible, then 50% coinsurance	Deductible, then 50% coinsurance
Hospital: Inpatient Admission[4] (Ex. hospital room)(includes maternity, mental health and substance use)	Deductible, then 35% (tier 1) / 50% (tier 2) coinsurance	Deductible, then 30% (tier 1) / 50% (tier 2) coinsurance	Deductible, then 35% (tier 1) / 50% (tier 2) coinsurance
Hospital: Outpatient Surgery Hospital Facility[4] (includes maternity, mental health and substance use)	Deductible, then 35% (tier 1) / 50% (tier 2) coinsurance	Deductible, then 30% (tier 1) / 50% (tier 2) coinsurance	Deductible, then 35% (tier 1) / 50% (tier 2) coinsurance
Maternity (includes prenatal and postnatal care)	Deductible, then 35% coinsurance	Deductible, then 30% coinsurance	Deductible, then 35% coinsurance
Retail Pharmacy Deductible (for tiers with deductible, cost share applies after deductible)	Medical deductible applies	Tier 1: No deductible Tiers 2, 3, 4: Medical deductible applies	Medical deductible applies
Retail Pharmacy Tier 1 / Tier 2	35% / 35% coinsurance	$25 copay / 30% coinsurance	35% / 35% coinsurance
Retail Pharmacy Tier 3 / Tier 4	35% / 35% coinsurance	30% / 30% coinsurance	35% / 35% coinsurance
Dental and Vision	Pediatric dental and vision covered Adult dental and vision not covered	Pediatric dental and vision covered Adult dental and vision not covered	Pediatric dental and vision covered Adult dental and vision not covered
Physical and Occupational Therapy[4] (limit of 30 combined visits per member per year)	Deductible, then 35% (tier 1) / 50% (tier 2) coinsurance	Deductible, then 30% (tier 1) / 50% (tier 2) coinsurance	Deductible, then 35% (tier 1) / 50% (tier 2) coinsurance
Speech Therapy[4] (limit of 30 visits per member per year)	Deductible, then 35% (tier 1) / 50% (tier 2) coinsurance	Deductible, then 30% (tier 1) / 50% (tier 2) coinsurance	Deductible, then 35% (tier 1) / 50% (tier 2) coinsurance

[1] **Tiered hospitals:** Our plans offer a Tiered network. In-network hospitals are split into two categories, Tier 1 and Tier 2. You pay a lower cost share for hospitals in Tier 1. To see what tier a hospital is in, visit the **Find a Doctor** tool at anthem.com.
[2] Individual deductible, Individual out-of-pocket limit and coinsurance reflect In-network / Out-of-network cost share information, if applicable for the plan. All other cost share information is for in-network services only.
[3] **LiveHealth Online** web visits have the same PCP office visit cost share listed in the chart.
[4] Cost share shows Tier 1 / Tier 2 coinsurance for hospitals in our network.

	Anthem HealthKeepers Bronze POS 0% for HSA (1X55)	Anthem HealthKeepers Bronze 5500/25% (1GB8)	Anthem HealthKeepers Bronze 15% for HSA (1GB7)
Network Name[1]	Pathway Tiered Hospital	Pathway Tiered Hospital	Pathway Tiered Hospital
Plan includes out-of-network coverage?[1]	Yes	No	No
Individual Deductible[2]	$5,350 / $10,700 In-network / Out-of-network	$5,500	$6,000
Individual Out-of-pocket Limit[2]	$6,550 / $18,000 In-network / Out-of-network	$6,850	$6,550
Coinsurance[2]	0% / 30% coinsurance In-network / Out-of-network	25% coinsurance	15% coinsurance
Office Visit: Primary Care Physician (PCP)[3] NOTE: Other office services subject to deductible and plan coinsurance.	Deductible, then 0% coinsurance	$40 copay per visit for first 2 office visits, then deductible and 25% coinsurance	Deductible, then 15% coinsurance
Office Visit: Specialist	Deductible, then 0% coinsurance	Deductible, then 25% coinsurance	Deductible, then 15% coinsurance
Outpatient Diagnostic (Ex. X-ray, Lab) **and Outpatient Advanced Diagnostic Tests** (Ex. MRI, CT scan)[4]	Deductible, then 0% coinsurance	Deductible, then 25% (tier 1) / 50% (tier 2) coinsurance	Deductible, then 15% coinsurance
Urgent Care	Deductible, then 0% coinsurance	Deductible, then 25% coinsurance	Deductible, then 15% coinsurance
Emergency Room Care	Deductible, then 20% coinsurance	Deductible, then 45% coinsurance	Deductible, then 35% coinsurance
Hospital: Inpatient Admission[4] (Ex. hospital room)(includes maternity, mental health and substance use)	Deductible, then 0% coinsurance	Deductible, then 25% (tier 1) / 50% (tier 2) coinsurance	Deductible, then 15% coinsurance
Hospital: Outpatient Surgery Hospital Facility[4] (includes maternity, mental health and substance use)	Deductible, then 0% coinsurance	Deductible, then 25% (tier 1) / 50% (tier 2) coinsurance	Deductible, then 15% coinsurance
Maternity (includes prenatal and postnatal care)	Deductible, then 0% coinsurance	Deductible, then 25% coinsurance	Deductible, then 15% coinsurance
Retail Pharmacy Deductible (for tiers with deductible, cost share applies after deductible)	Medical deductible applies	Medical deductible applies	Medical deductible applies
Retail Pharmacy Tier 1 / Tier 2	20% / 20% coinsurance	25% / 25% coinsurance	15% / 15% coinsurance
Retail Pharmacy Tier 3 / Tier 4	20% / 20% coinsurance	25% / 25% coinsurance	15% / 15% coinsurance
Dental and Vision	Pediatric dental and vision covered Adult dental and vision not covered	Pediatric dental and vision covered Adult dental and vision not covered	Pediatric dental and vision covered Adult dental and vision not covered
Physical and Occupational Therapy[4] (limit of 30 combined visits per member per year)	Deductible, then 0% coinsurance	Deductible, then 25% (tier 1) / 50% (tier 2) coinsurance	Deductible, then 15% coinsurance
Speech Therapy[4] (limit of 30 visits per member per year)	Deductible, then 0% coinsurance	Deductible, then 25% (tier 1) / 50% (tier 2) coinsurance	Deductible, then 15% coinsurance

[1]**Tiered hospitals:** Our plans offer a Tiered network. In-network hospitals are split into two categories, Tier 1 and Tier 2. You pay a lower cost share for hospitals in Tier 1. To see what tier a hospital is in, visit the **Find a Doctor** tool at anthem.com.
[2]Individual deductible, Individual out-of-pocket limit and coinsurance reflect In-network / Out-of-network cost share information, if applicable for the plan. All other cost share information is for in-network services only.
[3]**LiveHealth Online** web visits have the same PCP office visit cost share listed in the chart.
[4]Cost share shows Tier 1 / Tier 2 coinsurance for hospitals in our network.

	Anthem HealthKeepers Bronze 50% for HSA (1X4X)	Anthem HealthKeepers Silver 1550/30% (1GBG)	Anthem HealthKeepers Silver POS 2000/20% (1GBF)
Network Name[1]	Pathway Tiered Hospital	Pathway Tiered Hospital	Pathway Tiered Hospital
Plan includes out-of-network coverage?[1]	No	No	Yes
Individual Deductible[2]	$6,100	$1,550	$2,000 / $4,000 In-network / Out-of-network
Individual Out-of-pocket Limit[2]	$6,550	$6,850	$6,850 / $12,000 In-network / Out-of-network
Coinsurance[2]	50% coinsurance	30% coinsurance	20% / 30% coinsurance In-network / Out-of-network
Office Visit: Primary Care Physician (PCP)[3] NOTE: Other office services subject to deductible and plan coinsurance.	Deductible, then 50% coinsurance	$35 copay per visit for first 3 office visits, then deductible and 30% coinsurance	$20 copay per visit for first 5 office visits, then deductible and 20% coinsurance (Visit limits for PCP and Specialist are combined.)
Office Visit: Specialist	Deductible, then 50% coinsurance	Deductible, then 30% coinsurance	$65 copay per visit for first 5 office visits, then deductible and 20% coinsurance (Visit limits for PCP and Specialist are combined.)
Outpatient Diagnostic (Ex. X-ray, Lab) **and Outpatient Advanced Diagnostic Tests** (Ex. MRI, CT scan)[4]	Deductible, then 50% coinsurance	Deductible, then 30% (tier 1) / 50% (tier 2) coinsurance	Deductible, then 20% (tier 1) / 50% (tier 2) coinsurance
Urgent Care	Deductible, then 50% coinsurance	Deductible, then 30% coinsurance	Deductible, then 20% coinsurance
Emergency Room Care	Deductible, then 50% coinsurance	Deductible, then 50% coinsurance	Deductible, then 40% coinsurance
Hospital: Inpatient Admission[4] (Ex. hospital room)(includes maternity, mental health and substance use)	Deductible, then 50% coinsurance	Deductible, then 30% (tier 1) / 50% (tier 2) coinsurance	Deductible, then 20% (tier 1) / 50% (tier 2) coinsurance
Hospital: Outpatient Surgery Hospital Facility[4] (includes maternity, mental health and substance use)	Deductible, then 50% coinsurance	Deductible, then 30% (tier 1) / 50% (tier 2) coinsurance	Deductible, then 20% (tier 1) / 50% (tier 2) coinsurance
Maternity (includes prenatal and postnatal care)	Deductible, then 50% coinsurance	Deductible, then 30% coinsurance	Deductible, then 20% coinsurance
Retail Pharmacy Deductible (for tiers with deductible, cost share applies after deductible)	Medical deductible applies	Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies	Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies
Retail Pharmacy Tier 1 / Tier 2	50% / 50% coinsurance	$15 / $50 copay	$15 / $50 copay
Retail Pharmacy Tier 3 / Tier 4	50% / 50% coinsurance	30% / 30% coinsurance	20% / 20% coinsurance
Dental and Vision	Pediatric dental and vision covered Adult dental and vision not covered	Pediatric dental and vision covered Adult dental and vision not covered	Pediatric dental and vision covered Adult dental and vision not covered
Physical and Occupational Therapy[4] (limit of 30 combined visits per member per year)	Deductible, then 50% coinsurance	Deductible, then 30% (tier 1) / 50% (tier 2) coinsurance	Deductible, then 20% (tier 1) / 50% (tier 2) coinsurance
Speech Therapy[4] (limit of 30 visits per member per year)	Deductible, then 50% coinsurance	Deductible, then 30% (tier 1) / 50% (tier 2) coinsurance	Deductible, then 20% (tier 1) / 50% (tier 2) coinsurance

[1] **Tiered hospitals:** Our plans offer a Tiered network. In-network hospitals are split into two categories, Tier 1 and Tier 2. You pay a lower cost share for hospitals in Tier 1. To see what tier a hospital is in, visit the **Find a Doctor** tool at anthem.com.
[2] Individual deductible, Individual out-of-pocket limit and coinsurance reflect In-network / Out-of-network cost share information, if applicable for the plan. All other cost share information is for in-network services only.
[3] **LiveHealth Online** web visits have the same PCP office visit cost share listed in the chart.
[4] Cost share shows Tier 1 / Tier 2 coinsurance for hospitals in our network.

	Anthem HealthKeepers Silver 2250/20% (1GBE)	Anthem HealthKeepers Silver 2600/20% (1GBD)	Anthem HealthKeepers Silver 3350/15% (1GBC)
Network Name[1]	Pathway Tiered Hospital	Pathway Tiered Hospital	Pathway Tiered Hospital
Plan includes out-of-network coverage?[1]	No	No	No
Individual Deductible[2]	$2,250	$2,600	$3,350
Individual Out-of-pocket Limit[2]	$6,850	$6,850	$6,850
Coinsurance[2]	20% coinsurance	20% coinsurance	15% coinsurance
Office Visit: Primary Care Physician (PCP)[3] NOTE: Other office services subject to deductible and plan coinsurance.	$35 copay per office visit, unlimited	$35 copay per visit for first 3 office visits, then deductible and 20% coinsurance	$45 copay per office visit, unlimited
Office Visit: Specialist	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 15% coinsurance
Outpatient Diagnostic (Ex. X-ray, Lab) **and Outpatient Advanced Diagnostic Tests** (Ex. MRI, CT scan)[4]	Deductible, then 20% (tier 1) / 50% (tier 2) coinsurance	Deductible, then 20% (tier 1) / 50% (tier 2) coinsurance	Deductible, then 15% (tier 1) / 45% (tier 2) coinsurance
Urgent Care	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 15% coinsurance
Emergency Room Care	Deductible, then 40% coinsurance	Deductible, then 40% coinsurance	Deductible, then 35% coinsurance
Hospital: Inpatient Admission[4] (Ex. hospital room)(includes maternity, mental health and substance use)	Deductible, then 20% (tier 1) / 50% (tier 2) coinsurance	Deductible, then 20% (tier 1) / 50% (tier 2) coinsurance	Deductible, then 15% (tier 1) / 45% (tier 2) coinsurance
Hospital: Outpatient Surgery Hospital Facility[4] (includes maternity, mental health and substance use)	Deductible, then 20% (tier 1) / 50% (tier 2) coinsurance	Deductible, then 20% (tier 1) / 50% (tier 2) coinsurance	Deductible, then 15% (tier 1) / 45% (tier 2) coinsurance
Maternity (includes prenatal and postnatal care)	Deductible, then 20% coinsurance	Deductible, then 20% coinsurance	Deductible, then 15% coinsurance
Retail Pharmacy Deductible (for tiers with deductible, cost share applies after deductible)	Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies	Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies	Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies
Retail Pharmacy Tier 1 / Tier 2	$20 / $50 copay	$15 / $50 copay	$15 / $50 copay
Retail Pharmacy Tier 3 / Tier 4	20% / 20% coinsurance	20% / 20% coinsurance	15% / 15% coinsurance
Dental and Vision	Pediatric dental and vision covered Adult dental and vision not covered	Pediatric dental and vision covered Adult dental and vision not covered	Pediatric dental and vision covered Adult dental and vision not covered
Physical and Occupational Therapy[4] (limit of 30 combined visits per member per year)	Deductible, then 20% (tier 1) / 50% (tier 2) coinsurance	Deductible, then 20% (tier 1) / 50% (tier 2) coinsurance	Deductible, then 15% (tier 1) / 45% (tier 2) coinsurance
Speech Therapy[4] (limit of 30 visits per member per year)	Deductible, then 20% (tier 1) / 50% (tier 2) coinsurance	Deductible, then 20% (tier 1) / 50% (tier 2) coinsurance	Deductible, then 15% (tier 1) / 45% (tier 2) coinsurance

[1] **Tiered hospitals:** Our plans offer a Tiered network. In-network hospitals are split into two categories, Tier 1 and Tier 2. You pay a lower cost share for hospitals in Tier 1. To see what tier a hospital is in, visit the **Find a Doctor** tool at anthem.com.
[2] Individual deductible, Individual out-of-pocket limit and coinsurance reflect In-network / Out-of-network cost share information, if applicable for the plan. All other cost share information is for in-network services only.
[3] **LiveHealth Online** web visits have the same PCP office visit cost share listed in the chart.
[4] Cost share shows Tier 1 / Tier 2 coinsurance for hospitals in our network.

	Anthem HealthKeepers Gold 750/20% (1GBJ)	Anthem HealthKeepers Gold POS 1100/15% (1GBH)	Anthem HealthKeepers Catastrophic 6850/0% (1GB6)
Network Name[1]	Pathway Tiered Hospital	Pathway Tiered Hospital	Pathway Tiered Hospital
Plan includes out-of-network coverage?[1]	No	Yes	No
Individual Deductible[2]	$750	$1,100 / $2,200 In-network / Out-of-network	$6,850
Individual Out-of-pocket Limit[2]	$5,200	$4,800 / $12,000 In-network / Out-of-network	$6,850
Coinsurance[2]	20% coinsurance	15% / 30% coinsurance In-network / Out-of-network	0% coinsurance
Office Visit: Primary Care Physician (PCP)[3] NOTE: Other office services subject to deductible and plan coinsurance.	$30 copay per office visit, unlimited	$20 copay per office visit, unlimited	$40 copay per visit for first 3 office visits, then deductible and 0% coinsurance
Office Visit: Specialist	Deductible, then 20% coinsurance	$50 copay per office visit, unlimited	Deductible, then 0% coinsurance
Outpatient Diagnostic (Ex. X-ray, Lab) **and Outpatient Advanced Diagnostic Tests** (Ex. MRI, CT scan)[4]	Deductible, then 20% (tier 1) / 50% (tier 2) coinsurance	Deductible, then 15% (tier 1) / 45% (tier 2) coinsurance	Deductible, then 0% coinsurance
Urgent Care	Deductible, then 20% coinsurance	Deductible, then 15% coinsurance	Deductible, then 0% coinsurance
Emergency Room Care	Deductible, then 40% coinsurance	Deductible, then 35% coinsurance	Deductible, then 0% coinsurance
Hospital: Inpatient Admission[4] (Ex. hospital room)(includes maternity, mental health and substance use)	Deductible, then 20% (tier 1) / 50% (tier 2) coinsurance	Deductible, then 15% (tier 1) / 45% (tier 2) coinsurance	Deductible, then 0% coinsurance
Hospital: Outpatient Surgery Hospital Facility[4] (includes maternity, mental health and substance use)	Deductible, then 20% (tier 1) / 50% (tier 2) coinsurance	Deductible, then 15% (tier 1) / 45% (tier 2) coinsurance	Deductible, then 0% coinsurance
Maternity (includes prenatal and postnatal care)	Deductible, then 20% coinsurance	Deductible, then 15% coinsurance	Deductible, then 0% coinsurance
Retail Pharmacy Deductible (for tiers with deductible, cost share applies after deductible)	Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies	Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies	Medical deductible applies
Retail Pharmacy Tier 1 / Tier 2	$15 / $50 copay	$15 / $40 copay	0% / 0% coinsurance
Retail Pharmacy Tier 3 / Tier 4	20% / 20% coinsurance	15% / 15% coinsurance	0% / 0% coinsurance
Dental and Vision	Pediatric dental and vision covered Adult dental and vision not covered	Pediatric dental and vision covered Adult dental and vision not covered	Pediatric dental and vision covered Adult dental and vision not covered
Physical and Occupational Therapy[4] (limit of 30 combined visits per member per year)	Deductible, then 20% (tier 1) / 50% (tier 2) coinsurance	Deductible, then 15% (tier 1) / 45% (tier 2) coinsurance	Deductible, then 0% coinsurance
Speech Therapy[4] (limit of 30 visits per member per year)	Deductible, then 20% (tier 1) / 50% (tier 2) coinsurance	Deductible, then 15% (tier 1) / 45% (tier 2) coinsurance	Deductible, then 0% coinsurance

[1] **Tiered hospitals:** Our plans offer a Tiered network. In-network hospitals are split into two categories, Tier 1 and Tier 2. You pay a lower cost share for hospitals in Tier 1. To see what tier a hospital is in, visit the **Find a Doctor** tool at anthem.com.
[2] Individual deductible, Individual out-of-pocket limit and coinsurance reflect In-network / Out-of-network cost share information, if applicable for the plan. All other cost share information is for in-network services only.
[3] **LiveHealth Online** web visits have the same PCP office visit cost share listed in the chart.
[4] Cost share shows Tier 1 / Tier 2 coinsurance for hospitals in our network.

Dental stand-alone plans benefit chart

	Anthem Dental Pediatric (Dependents age 18 and younger)	**Anthem Dental Family** (Dependents age 18 and younger)	**Anthem Dental Family** (Adults age 19+)	**Anthem Dental Family Enhanced** (Dependents age 18 and younger)
	In-network / Out-of-network	**In-network / Out-of-network**	**In-network / Out-of-network**	**In-network / Out-of-network**
Dental Network	Dental Prime	Dental Prime	Dental Prime	Dental Prime
Deductible (per person, all services)	$50 / $50	$50 / $50	$50 / $50	$25 / $25
Annual maximum[1] (per person)	None	None	$750 / $750	None
Annual out-of-pocket limit[2]	$350[3] / None	$350[3] / None	None	$350[3] / None
Diagnostic and Preventive	No waiting period	No waiting period	No waiting period	No waiting period
Cleaning, exams, x-rays	0% / 30% coinsurance	0% / 30% coinsurance	0% / 50% coinsurance	0% / 20% coinsurance
Extra cleaning	Not covered	Not covered	Not covered	Not covered
Basic services	No waiting period	No waiting period	6-month waiting period	No waiting period
Fillings	40% / 50% coinsurance	40% / 50% coinsurance	50% / 75% coinsurance	20% / 40% coinsurance
Brush biopsy	Not covered	Not covered	Not covered	Not covered
Complex & major services	No waiting period	No waiting period	12-month waiting period	No waiting period[4]
Endodontic/periodontic/oral surgery (root canal, scaling, tooth removal)	50% / 50% coinsurance	50% / 50% coinsurance	70% / 85% coinsurance	20% / 50% coinsurance
Prosthetics (crowns, dentures, bridges)	50% / 50% coinsurance	50% / 50% coinsurance	70% / 85% coinsurance	50% / 50% coinsurance
Medically necessary orthodontia	50% / 50% coinsurance	50% / 50% coinsurance	Not covered	50% / 50% coinsurance
Cosmetic orthondontia	Not covered	Not covered	Not covered	50% / 50% coinsurance[5]
International emergency dental program	Included	Included	Included	Included

[1]Once the plan has paid the **Annual maximum** per person, the plan will not pay any more benefits for the rest of that calendar year.
[2]**Out-of-pocket limit** is the most you pay during a calendar year before your plan begins to pay 100% of the maximum allowed amount.
[3]Per child, up to two children.
[4]Except 12-month waiting period for **Medically necessary** and **Cosmetic orthodontia.**
[5]$1,000 lifetime maximum for **Cosmetic orthodontia.**
Dental plans underwritten by Anthem Blue Cross and Blue Shield.

	Anthem Dental Family Enhanced (Adults age 19+)	**Dental Prime Plan A**	**Dental Prime Plan B**	**Dental Prime Plan C**
	In-network / Out-of-network	**In-network / Out-of-network**	**In-network / Out-of-network**	**In-network / Out-of-network**
Dental Network	Dental Prime	Dental Prime	Dental Prime	Dental Prime
Deductible (per person, all services)	$50 / $50	None	$50 / $50	$50 / $50
Annual maximum[1] (per person)	$1,000 / $1,000	$500 / $500	$1,000 / $1,000	$1,250 / $1,250
Annual out-of-pocket limit[2]	None	None	None	None
Diagnostic and Preventive	No waiting period	No waiting period	No waiting period	No waiting period
Cleaning, exams, x-rays	0% / 50% coinsurance	0% / 0% coinsurance	0% / 0% coinsurance	0% / 0% coinsurance
Extra cleaning	Not covered	1 extra cleaning per year for those who are pregnant or diabetic	1 extra cleaning per year for those who are pregnant or diabetic	1 extra cleaning per year for those who are pregnant or diabetic
Basic services	6-month waiting period	Not covered	6-month waiting period	6-month waiting period
Fillings	20% / 60% coinsurance	Not covered	20% / 20% coinsurance	20% / 20% coinsurance
Brush biopsy	Not covered	Not covered	20% / 20% coinsurance	20% / 20% coinsurance
Complex & major services	12-month waiting period	Not covered	12-month waiting period	12-month waiting period
Endodontic/periodontic/oral surgery (root canal, scaling, tooth removal)	50% / 75% coinsurance	Not covered	50% / 50% coinsurance	50% / 50% coinsurance
Prosthetics (crowns, dentures, bridges)	50% / 75% coinsurance	Not covered	Not covered	50% / 50% coinsurance
Medically necessary orthodontia	Not covered	Not covered	Not covered	Not covered
Cosmetic orthondontia	Not covered	Not covered	Not covered	Not covered
International emergency dental program	Included	Included	Included	Included

[1]Once the plan has paid the **Annual maximum** per person, the plan will not pay any more benefits for the rest of that calendar year.
[2]**Out-of-pocket limit** is the most you pay during a calendar year before your plan begins to pay 100% of the maximum allowed amount.
[3]Per child, up to two children.
[4]Except 12-month waiting period for **Medically necessary** and **Cosmetic orthodontia.**
[5]$1,000 lifetime maximum for **Cosmetic orthodontia.**
Dental plans underwritten by Anthem Blue Cross and Blue Shield.

Our plans' built-in extras

At HealthKeepers, we want to be more than your health benefits provider — we want to help you meet your day-to-day health and wellness goals. That's why we offer a variety of programs, discounts and tools to support you being your healthy best.

Health and wellness programs

From online health assessments and personal coaching to pregnancy and disease management support, we're here to give you the guidance you need, when you need it — at no extra cost. ***Here's how:***

- **24/7 Nurseline -** Day or night, you can talk to a registered nurse about your health concerns or ask specific questions about a condition you're managing (like asthma or diabetes) through our 24/7 NurseLine. Whether it's a question about allergies, the flu or choosing between the ER or urgent care, our nurses are always there for you.
- **ConditionCare -** Your health is our top priority. If you have an ongoing or complex health problem, a case manager may call you to see how we can help manage your condition and give you information and emotional support services.
- If you need extra support in managing your health or a specific health condition (like asthma or diabetes), the preventive care services included with your plan are covered at 100% when you use in-network providers and can help you improve your health and well-being.

  These are just some of the routine preventive care services we offer you:
  - Primary care doctor office visits to help you discuss your condition
  - Lab tests that ensure you're on your wellness path
  - Blood tests to measure your cholesterol, triglycerides, and lipoproteins (HDL and LDL)
  - Health screenings like routine ECG, ultrasound and more
  - Comprehensive metabolic panels to measure your sugar (glucose) level, electrolyte and fluid balance, as well as kidney and liver function

And don't forget about those regular checkups! Your yearly exams, flu shots and other preventive care services are covered 100% with your health plan when you see a provider in the network. So you never have to think twice about calling your doctor and scheduling what you need.

SpecialOffers@Anthem℠

SpecialOffers@Anthem℠ (SpecialOffers) is our member discount program for health- and wellness-related products and services.

Through the program, members enjoy discounts on:

- Vitamins
- Health and beauty products
- Massage therapy
- LASIK eye surgery
- Eyeglass frames and contact lenses
- Hearing aids and services
- Jenny Craig® and Weight Watchers® weight-loss programs*
- Smoking cessation programs

To view all our SpecialOffers discounts, log in to anthem.com and select **Discounts** on the ***Main Overview*** page.

*Weight Watchers and PointsPlus are the registered trademarks of Weight Watchers International, Inc. Trademarks used under license by WeightWatchers.com, Inc.

Enhanced Personal Health Care

Enhanced Personal Health Care is a new kind of doctor-patient relationship created just for HealthKeepers members!

We put members in a unique circle of care, making them the central focus of a team approach to their overall health. **Enhanced Personal Health Care** — a program that:

- Improves your patient experience with better access to a primary care doctor who cares for the "whole person" and becomes your health care champion and helps you navigate the health care system.
- Gives doctors added support with the right tools and strategies to help strengthen your doctor-patient relationship, so doctors can spend more time with you and coordinate your care with other doctors.

Together, you and your doctor work to make the best choices for your health care.

Travel coverage

With the Blue Cross and Blue Shield Association's BlueCard® program, you can access care no matter where you are in the U.S.

Whether you're traveling for work or on vacation, going to the ER or urgent care is probably the last thing you want to worry about. The good news is that our plans cover medically necessary emergency and urgent care in all 50 states. Our Anthem HealthKeepers POS plans also include additional coverage for non-emergency/urgent care when you visit participating BlueCard providers.

Online tools

From our website and mobile app to cost and quality comparison tools, we want to make sure you have the information you need to make informed health care decisions for you and your family.

With our secure website, you can:

- Get a breakdown of what is and isn't covered by your plan through a benefit summary.
- See your recent claims and coverage details.
- Pay your premium online.
- Estimate your costs before having certain procedures.

With our mobile app, you can:

- Search for a nearby in-network doctor, specialist, urgent care center or hospital.
- Get turn-by-turn directions to get there.
- Manage your prescription drug benefits, including pricing medications, switching from retail to home delivery and ordering refills.
- Carry a virtual member ID card.

Cost and quality information with Estimate Your Cost

With our Estimate Your Cost tool, you can save time and money by comparing the cost of common procedures at health care facilities in your area. You'll also get to see the quality and safety ratings for those facilities.

LiveHealth Online[1]

LiveHealth Online is a convenient way for you and your family to talk face-to-face with a board-certified doctor when your own doctor isn't available.[2] Just use your computer or mobile device to access medical care when you need it, 24/7.

No appointments, no driving and no waiting at an urgent care center. All you have to do is sign up at **livehealthonline.com** or download the app.

Once you become a member and register with LiveHealth Online, you can:

- Get medical advice, diagnoses, proper treatment and even prescriptions, as needed.[3]
- Quickly address common health problems, like allergies, colds, rashes, fever and more.
- See a doctor via video chat in minutes.

LiveHealth Online visits cost $49 or less depending on your health plan. It is currently available in English and Spanish.

[1] LiveHealth Online is the trade name of the Health Management Corporation.
[2] LiveHealth Online is offered in most states and is expected to expand into more areas in the near future. Visit the home page at **livehealthonline.com** to see the latest map showing where service is available.
[3] This is legally permitted only in certain states.

Register at anthem.com for online access.

Once you're a member, register at **anthem.com** to access your benefits online. Choose **Register Now** on the top right-hand side of your screen.

Ready to enroll?

If you're ready to take the next step and enroll, we're here to help you every step of the way.

To get started, you'll need to have the following information handy:

- Employer and income details (for example, pay stubs and W-2 forms) for every member of your household who needs coverage
- Policy numbers and insurer names for any current health insurance plans covering members of your household
- Name of every job-based health insurance plan for which you or someone in your household is eligible

Then, you can:

- Call your authorized sales representative to enroll or learn more about our health care plans. Take a look at the application included with this brochure.
- Visit our website at anthem.com and apply online.

Generally, plans can be purchased once a year through an open enrollment period. This year, the open enrollment period runs from November 1, 2015 through January 31, 2016. Be sure to enroll by December 15, 2015, to start coverage effective January 1, 2016.

The annual open enrollment period may vary from year to year, so you should check with your HealthKeepers authorized sales representative for specific dates.

Your HealthKeepers authorized sales representative is here to help you enroll. You can also apply online at anthem.com.

We want you to be satisfied

After you enroll in one of our plans, you'll receive an *Evidence of Coverage* that explains the exact terms and conditions of coverage, including exclusions and limitations. You'll have 10 days to examine your *Evidence of Coverage's* features. If you're not fully satisfied during that time, you may cancel your *Evidence of Coverage* and your premium will be refunded, minus any claims that were already paid.

This document is only a brief summary of benefits and services. Our plans have exclusions, limitations and terms under which the *Evidence of Coverage* may be continued in force or discontinued. For more complete details on what's covered and what isn't:

- Review the *Evidence of Coverage*.
- Call your HealthKeepers authorized sales representative.
- Go to anthem.com.

To access a ***Summary of Benefits and Coverage*** (SBC), please visit www.sbc.anthem.com and select **Member**.

The health plans described in this document aren't eligible for a premium tax credit or subsidy/cost-sharing assistance. The Affordable Care Act (ACA) helps people with low or modest incomes pay for their health insurance with a premium tax credit or subsidy. You can only get financial help if you're eligible and you buy your individual health coverage through the Health Insurance Marketplace.

In compliance with the ACA, the following plan changes may occur annually on January 1:

- Benefits
- Formularies
- Pharmacy and provider networks
- Premiums, copays and coinsurance

Still have questions?

Please reach out to your authorized sales representative. If you're stuck and unsure about next steps, we're here to listen and offer advice. We know there's a great plan out there just for you - let us help you find it!

Important plan information

Before choosing a health benefit plan, please review the following information along with the other materials enclosed.

Eligibility

You can apply for coverage for yourself or with your family. You must be a resident of the State of Virginia and not entitled to or enrolled in Medicare. Family health coverage includes you, your spouse or domestic partner and any dependent children. Children are covered to the end of the month in which they turn age 26.

Eligibility for a catastrophic plan

You are eligible for this plan if you:

- are under age 30 before the plan's effective date; or
- have received certification from the Health Insurance Marketplace that you are exempt from the individual mandate because you qualify for a hardship exemption or do not have an affordable coverage option

Open Enrollment

An annual open enrollment period is provided for enrollees. Individuals may enroll in a plan, and members may change benefit plans at that time.

Special Enrollment and Changes Affecting Eligibility

In addition to open enrollment, an individual can enroll during the special enrollment period. This is a period of time in which eligible individuals or their dependents can enroll after the open enrollment, typically due to an event such as marriage, birth, adoption, or other qualifying events as defined by law.

Depending on the event which triggers the special enrollment period, coverage may be effective as of the date of the qualifying event.

Effective Date of Coverage

The earliest effective date for the annual open enrollment period is the first day of the following calendar year. The actual effective date is determined by the date HealthKeepers receives a complete application with the applicable premium payment.

Managing your care if you need to go to a hospital or get certain medical treatment

If you or a family member need certain types of medical care (for example: surgery, treatment in a doctor's office, physical therapy, etc.), you may want to know more about these programs and terms. They may help you better understand your benefits and how your health plan manages these types of care.

Utilization Management

Utilization management (UM) is a program that is part of your health plan. It lets us make sure you're getting the right care at the right time. Our UM review team, made up of licensed health care professionals such as nurses and doctors, does medical reviews. The team goes over the information your doctor has sent us to see if the requested surgery, treatment or other type of care is medically necessary. The UM review team checks to make sure the treatment meets certain clinical guidelines set by your health plan. After reviewing the records and information, the team will approve (cover) or deny (not cover) the treatment. The UM review team will let you and your doctor know as soon as possible. Decisions not to approve are put in writing. The written notice will include information on how to appeal the decision and about your rights to an independent medical review.

We can do medical reviews like this before, during and after a member's treatment. Here's an explanation of each type of review:

The prospective or pre-service review (done before you get medical care)

We may do a prospective review before a member goes to the hospital or has other types of services or treatment. Here are some types of medical treatments that might call for a prospective review:

- An inpatient hospital visit;
- An outpatient procedure;
- Tests to find the cause of an illness, like magnetic resonance imaging (MRI) and computed tomography (CT) scans;
- Certain types of outpatient therapy, like physical therapy or mental health counseling;
- Durable medical equipment (DME), like wheelchairs, walkers, crutches, hospital beds and more

The concurrent review (done during medical care and recovery)

We do a concurrent review when you are in the hospital or are released and need more care related to the hospital stay. This could mean services or treatment in a doctor's office, regular office visits, physical therapy or mental health therapy, home health care, durable medical equipment, a stay in a nursing home, mental health care visits and more. The UM review team looks at the member's medical information at the time of the review to see if the treatment is medically necessary.

The retrospective or post-service review (done after you get medical care)

We do a retrospective review when you have already had surgery or another type of medical care. When the UM review team learns about the treatment, they look at the medical information the doctor or provider had about you at the time the medical care was given. The team then can see if the treatment was medically necessary.

Case Management

Case managers are licensed health care professionals who work with you and your doctor to help you learn about and manage your health conditions. They also help you better understand your health benefits.

Preauthorization

Preauthorization is the process of getting approval from your health plan before you get services. This process lets you know if we will cover a service, supply, therapy or drug. We approve services that meet our standards for needed and appropriate treatment. The guidelines we use to approve treatment are based on standards of care in medical policies, clinical guidelines and the terms of your plan. As these may change, we review our preauthorization guidelines regularly. Preauthorization is also called "precertification," "prior authorization," or "pre-approval."

Here's how getting preauthorization can help you out:

Saving time. Preauthorizing services can save a step since you will know if you are eligible and what your benefits are before you get the service. The doctors in our network ask for preauthorization for our members.

Saving money. Paying only for medically necessary services helps everyone save. Choosing a doctor who's in our network can help you get the most for your health care dollar.

What can you do? Choose a in-network doctor. Talk to your doctor about your conditions and treatment options. Ask your doctor which covered services need preauthorization or call us to ask. The doctor's office will ask for preauthorization for you. Plus, costs are usually lower with an in-network doctor. If you choose an out-of-network provider, be sure to call us to see if you need preauthorization. Out-of-network providers may not do that for you. It is important to understand that not all plans offer out of network coverage, with the exception of emergency or urgent

care. Please review the Evidence of Coverage in order to determine your benefits. If you ever have a question about whether you need preauthorization, just call the preauthorization or precertification phone number on your ID card.

In-network Providers

In-network providers are the key to providing and coordinating your health care services. Benefits are provided when you obtain covered services from providers in our Pathway Tiered Hospital network. It's a good idea to have a primary care physician (PCP) for things like checkups and health issues that need ongoing care; but you're not required to select a PCP or get a referral to seek care from in-network specialty physicians.

Services you obtain from any provider outside of our network are considered out-of-network services and are not covered, with the exception of emergency care or urgent care, or a service that is authorized in advance by HealthKeepers.

We do offer Point of Service (POS) plans that cover out-of-network care. With our POS plans, services will be covered services if rendered by out-of-network providers, but your share of the costs may be greater.

For POS Plans

Services for non-emergency or non-urgent care using an out-of-network provider in or out of the Anthem HealthKeepers' service area will be covered at the out-of-network cost shares and you could be subject to balance billing for the amount charged above HealthKeepers' maximum allowed amount for the service.

Services for non-emergency or non-urgent care provided by a BlueCard® provider in the PAR network, outside of Anthem HealthKeepers' service area, will be covered at the out-of-network cost shares, but you will be protected from balance billing.

To find out if a provider is in the BlueCard program's PAR network, call 1-800-810-BLUE (2583).

For HMO plans

The only services covered outside our network are emergency and urgent care services. In addition, you will have emergency and urgent care coverage through the Blue Cross and Blue Shield Association's BlueCard® program using the Participating (PAR) network.

Laws and rights that protect you

As a member, you have rights and responsibilities. You have the right to expect the privacy of your personal health information to be protected, consistent with state and federal laws and our policies. You also have certain rights and responsibilities when receiving your health care. Visit this link to find more information on our website: http://www.anthem.com/health-insurance/customer-care/faq.

Limitations - Medical plans

The specific limitations are spelled out in the terms of the particular plan, but some of the more common services limited by these plans are:

- Ambulance services (non-emergency transportation) - $50,000 per occurrence if an out-of-network provider is used
- Chiropractic – 30 visits for spinal manipulation per member per year
- Home health care – 100 visits per member per year
- Private duty nursing provided in a home care setting - 16 hours per member per year
- Skilled nursing facility – 100 days per stay
- Therapy services:
  - Physical/Occupational therapy - 30 combined visits per member per year
  - Speech therapy - 30 visits per member per year

Limitations – Anthem dental pediatric embedded plan, essential health benefits

Diagnostic and Preventive Services

- **Oral Exams** - covered once per 6 months.
- **Radiographs (X-rays)** - individual x-rays taken on the same day will be limited to the maximum allowed amount for a full mouth (complete series).
  - Bitewings - covered at 1 series of bitewings per year.
  - Full Mouth (Complete Series) - covered 1 time per 60-month period.
  - Panoramic – covered 1 time per 60-month period.
  - Periapicals and extraorals - covered as needed per diagnosis.
  - Occlusal – 2 per 12-month period.
  - Dental Cleaning (Prophylaxis) – covered once every 6 months.
- **Space Maintainers** - covered 1 time per quadrant every 12 months.

Basic Restorative Services

- **Amalgam fillings** - covered for permanent and primary posterior (back) teeth.
- **Composite fillings** - covered for permanent and primary anterior (front) teeth. If you get a composite restorative on a posterior (back) tooth, it is considered and optional treatment and will be covered up to the maximum allowed amount for an amalgam filling. You will be responsible to pay the difference between the maximum allowed amount and the dentist's actual charge. This is in addition to any applicable deductible and/or coinsurance.
- **Fillings** - covered once per tooth surface per 12-month period.

Endodontic Services

- **Pulpotomies** - covered once per tooth per lifetime. Will not be covered if billed with root canal therapy.
- **Pulp cap (direct or indirect)** - covered once per tooth per lifetime.
- **Pulpal therapy** - covered once per tooth per lifetime.
- **Root Canal Therapy** - covered once per tooth per lifetime.
- **Retreatment of previous root canal** - covered once per tooth per lifetime.
- **Pulpal Regeneration** - covered once per tooth per lifetime.
- **Apicoectomy/Periradicular Surgery** - limited to 1 per lifetime per tooth.
- **Retrograde filling** - limited to 1 per lifetime per tooth.

Periodontal Services

- **Periodontal scaling & root planning** - covered once per 24 months per quadrant.
- **Crown Lengthening** - covered once per tooth per lifetime.
- **Full Mouth Debridement** - covered once per 12 months.
- **Osseous Surgery** - covered once per 60 months per quadrant.
- **Gingivectomy or gingivoplasty** - covered once per 24 month-period per quadrant.

Oral Surgery Services

- **Basic Extractions and Complex Surgical Extractions** - surgical removal of 3rd molars is only covered if the removal is associated with symptoms or oral pathology.
- **Adjunctive General Services**
  - Intravenous and Non-Intravenous Conscious Sedation and General Anesthesia – covered only when given with covered oral surgery services by a dentist or by an employee of the dentist when the service is performed in his or her office who is certified in their profession to provide anesthesia services. Covered up to a maximum of 150 minutes (10 units).

Major Restorative Services

- **Pre-fabricated, Stainless Steel, or Temporary Crown** - temporary crown not covered if used during crown fabrication.
- **Protective Restorations** - not covered in conjunction with root canal therapy, pulpotomy, pulpectomy, or on the same date of services as another restoration
- **Permanent Crowns** (full cast, titanium, high noble metal, porcelain only, or metal/porcelain) - covered 1 time per 60-month period if the tooth has extensive loss of natural tooth structure due to decay or tooth fracture such that a restoration cannot be used to restore the tooth. Covered for permanent teeth only.
- **Labial Veneers** - covered one per 60 months per tooth.

Prosthodontic Services

- **Removable Prosthetic Services (Dentures and Partials)** - covered 1 time per 60-month period.
- **Fixed Prosthetic Services (Bridge)** - covered once per tooth per 5 years.
- **Denture adjustments** - not covered within 6 months of placement.
- **Reline denture (chair or laboratory)** - covered once per 24-month period, not covered within 6 months of placement.

Orthodontic Services

Orthodontic Exclusions

We will not pay for services incurred for, or in connection with, any of the items below:

- Monthly treatment visits that are inclusive of treatment cost;
- Orthodontic retention/retainer as a separate service;
- Retreatment and/or services for any treatment due to relapse;
- Inpatient or outpatient hospital expenses; and
- Temporary procedures or interim stabilization of teeth.

Limitations – Anthem dental pediatric, family and family enhanced plans, essential health benefits

Diagnostic and Preventive Services

- **Oral Exams** - covered once per 6 months.
- **Radiographs (X-rays)** - individual x-rays taken on the same day will be limited to the maximum allowed amount for a full mouth (complete series).
  - Bitewings - covered at 1 series of bitewings per year.
  - Full Mouth (Complete Series) - covered 1 time per 60-month period.
  - Panoramic – covered 1 time per 60-month period.
  - Periapicals and extraorals - covered as needed per diagnosis.
  - Occlusal – 2 per 12-month period.
- **Dental Cleaning (Prophylaxis)** – covered once every 6 months.
- **Space Maintainers** - covered 1 time per quadrant every 12 months.

Basic Restorative Services

- **Amalgam fillings** - covered for permanent and primary posterior (back) teeth.
- **Composite fillings** - covered for permanent and primary anterior (front) teeth. If you get a composite restorative on a posterior (back) tooth, it is considered and optional treatment and will be covered up to the maximum allowed amount for an amalgam filling. You will be responsible to pay the difference between the maximum allowed amount and the dentist's actual charge. This is in addition to any applicable deductible and/or coinsurance.
- **Fillings** - covered once per tooth surface per 12-month period.

Endodontic Services

- **Pulpotomies** - covered once per tooth per lifetime. Will not be covered if billed with root canal therapy.
- **Pulp cap (direct or indirect)** - covered once per tooth per lifetime.
- **Pulpal therapy** - covered once per tooth per lifetime.
- **Root Canal Therapy** - covered once per tooth per lifetime.
- **Retreatment of previous root canal** - covered once per tooth per lifetime.
- **Pulpal Regeneration** - covered once per tooth per lifetime.
- **Apicoectomy/Periradicular Surgery** - limited to 1 per lifetime per tooth.
- **Retrograde filling** - limited to 1 per lifetime per tooth.

Periodontal Services

- **Periodontal scaling & root planning** - covered once per 24 months per quadrant.
- **Crown Lengthening** - covered once per tooth per lifetime.
- **Full Mouth Debridement** - covered once per 12 months.
- **Osseous Surgery** - covered once per 60 months per quadrant.
- **Gingivectomy or gingivoplasty** - covered once per 24 month-period per quadrant.

Oral Surgery Services

- **Basic Extractions and Complex Surgical Extractions** - surgical removal of 3rd molars is only covered if the removal is associated with symptoms or oral pathology.
- **Adjunctive General Services**
  - Intravenous and Non-Intravenous Conscious Sedation and General Anesthesia – covered only when given with covered oral surgery services by a dentist or by an employee of the dentist when the service is performed in his or her office who is certified in their profession to provide anesthesia services. Covered up to a maximum of 150 minutes (10 units).

Major Restorative Services

- **Pre-fabricated, Stainless Steel, or Temporary Crown** - temporary crown not covered if used during crown fabrication.
- **Protective Restorations** - not covered in conjunction with root canal therapy, pulpotomy, pulpectomy, or on the same date of services as another restoration.
- **Permanent Crowns** (full cast, titanium, high noble metal, porcelain only, or metal/porcelain) - covered 1 time per 60-month period if the tooth has extensive loss of natural tooth structure due to decay or tooth fracture such that a restoration cannot be used to restore the tooth. Covered for permanent teeth only.
- **Labial Veneers** - covered one per 60 months per tooth.

Prosthodontic Services

- **Removable Prosthetic Services (Dentures and Partials)** - covered 1 time per 60-month period.
- **Fixed Prosthetic Services (Bridge)** - covered once per tooth per 5 years.
- **Denture adjustments** - not covered within 6 months of placement.
- **Reline denture (chair or laboratory)** - covered once per 24-month period, not covered within 6 months of placement.

Orthodontic Services

- **Cosmetic Orthodontic Care** - You must be covered under this policy for 12 months before we will pay for this benefit. Covered persons age 8 through 18 may be eligible for cosmetic orthodontic care if the recommended treatment is not eligible for dentally necessary orthodontic care.

Orthodontic Exclusions

We will not pay for services incurred for, or in connection with, any of the items below:

- Monthly treatment visits that are inclusive of treatment cost;
- Orthodontic retention/retainer as a separate service;
- Retreatment and/or services for any treatment due to relapse;
- Inpatient or outpatient hospital expenses; and
- Temporary procedures or interim stabilization of teeth.

Adult dental benefits

Diagnostic and Preventive Services

- **Oral Evaluations** - any type of evaluation (checkup or exam) is covered 2 times per calendar year.
  - Comprehensive oral evaluations will be benefited 1 time per dental office, subject to the 2 times per calendar year limitation.
  - Any additional comprehensive oral evaluations performed by the same dental office will be benefited as a periodic oral evaluation and will be subject to the 2 times per calendar year limitation.
- **Radiographs (X-rays)**
  - **Bitewings** - covered at 1 series of bitewings per 24-month period.
  - **Full Mouth (Complete Series)** - covered 1 time per 60-month period.
  - **Periapical(s)** - 4 single x-rays covered per 12-month period.
  - **Occlusal** - covered at 2 series per 24-month period.
- **Dental Cleaning Prophylaxis** - any combination of this procedure and Periodontal Maintenance (See Periodontal Services) are covered 2 times per calendar year.

Basic Restorative Services

- **Amalgam (silver) Restorations and Composite (white) Resin Restorations** - coverage for amalgam or composite restorations limited to 1 service per tooth surface per 24-month period.
- **Basic Extractions**
  - **Brush Biopsy** - covered 1 time every 36 months for covered persons age 20 to 39, covered 1 time per 12 months for covered persons age 40 and above.

Endodontic Services

- **Endodontic Therapy on Primary Teeth**
  - Pulpal Therapy - covered 1 time per tooth per lifetime.
  - Therapeutic Pulpotomy - covered 1 time per tooth per lifetime.
- **Endodontic Therapy on Permanent Teeth**
  - Root Canal Therapy - covered 1 time per tooth per lifetime.
  - Root Canal Retreatment - covered 1 time per tooth per lifetime.

Periodontal Services

- **Periodontal Maintenance** - any combination of this procedure and dental cleanings (see Diagnostic and Preventive section) is covered 2 times per calendar year.
- **Periodontal scaling & root planing** - covered 1 time per 36 months if the tooth has a pocket depth of 4 millimeters or greater.
  - **Full mouth debridement** - covered 1 time per lifetime.
- **Complex Surgical Periodontal Care** – only 1 complex surgical periodontal service is covered 36-month period per single tooth or multiple teeth in the same quadrant and only if the pocket depth of the tooth is 5 millimeters or greater.
  - Gingivectomy/gingivoplasty;
  - Gingival flap;
  - Apically positioned flap;
  - Osseous surgery;
  - Bone replacement graft;
  - Pedicle soft tissue graft;
  - Free soft tissue graft;
  - Subepithelial connective tissue graft;
  - Soft tissue allograft;
  - Combined connective tissue and double pedicle graft;
  - Distal/proximal wedge - covered on natural teeth only

Oral Surgery Services

- Complex Surgical Extractions
- **Other Complex Surgical Procedures** - the following services are covered only when required to prepare for dentures and are limited to once in a 60-month period.
  - Alveoloplasty
  - Vestibuloplasty
  - Removal of exostosis-per site
  - Surgical reduction of osseous tuberosity

Major Restorative Services

- **Onlays and/or Permanent Crowns** - covered 1 time per 7-year period per tooth if the tooth has extensive loss of natural tooth structure due to decay or tooth fracture such that a restoration cannot be used to restore the tooth.
- **Crown Repair** - covered 1 time per 12-month period per tooth.
- **Restorative cast post and core build-up, including 1 post per tooth and 1 pin per surface** - covered 1 time per 7-year period.

Prosthodontic Services

- **Tissue Conditioning** - covered 1 time per 24-month period.
- **Reline and Rebase** - covered 1 per 24-month period.
- **Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s)** - covered 1 per 6-month period.
- **Denture Adjustments** - covered 2 times per 12-month period.
- **Partial and Bridge Adjustments** - covered 2 times per 24-month period.
- **Removable Prosthetic Services (Dentures and Partials)** - covered 1 time per 7-year period.
- **Fixed Prosthetic Services (Bridge)** - covered 1 time per 7-year period.
- **Recement Fixed Prosthetic** - covered 1 time per 12 months.
- **Single Tooth Implant Body, Abutment and Crown** - covered 1 time per 7-year period.

Limitations – Dental prime plans

- **Optional Treatment Plans:** If there are alternative treatments that have different costs, the final treatment decision is between you and your dentist. We will cover the treatment that is the least costly and which is the most commonly performed treatment. You will be responsible to pay for the difference in cost between the maximum allowed amount for the covered service and the optional treatment, plus any deductible and/or coverage percentage for the covered benefit.
- **Reconstructive Surgery:** Benefits will be provided for reconstructive surgery when dental care is incidental to or follows surgery resulting from injury, sickness or other diseases of the involved part, or when such dental care is performed on a covered dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician.
- **Dental orthodontic services** not related to the management of the congenital condition of cleft lip and cleft palate is not covered under the Evidence of Coverage.
- Some services are an integral part of another completed covered service by the Evidence of Coverage. If the dentist bills these procedures separately from the covered service, we will not pay for the separately billed procedures. You will then be responsible for any charge for the separately billed procedures and must pay your dentist directly.

Diagnostic and Preventive Services

- **Oral Evaluations** – any type of evaluation (checkup or exam) is covered 2 times per calendar year.
- **Bitewings** – covered at 1 series of bitewings per 12-month period for covered persons through the age of 17; 1 series of bitewings per 24-month period for covered persons age 18 and over.
- **Full Mouth (Complete Series) or Panoramic** – covered 1 time per 60-month period.
- **Periapical(s)** – 4 single x-rays are covered per 12-month period.
- **Occlusal** – covered at 2 series per 24-month period.
- **Prophylaxis** – any combination of this procedure and Periodontal Maintenance (See Periodontal Services) covered 2 times per calendar year.
- **Fluoride Treatment** (Topical application of fluoride) – covered 1 time per 12-month period Dependent children through the age of 18.
- **Fluoride Varnish** – covered 1 time per 12-month period for dependent children through the age of 18.
- **Sealants or Preventive Resin Restorations** – any combination of these procedures is covered 1 time per 12-month period for permanent first and second molars through the age of 15.

Basic Restorative Services

- **Amalgam Restorations** – 1 service per tooth surface per 24-month period.
- **Composite Resin Restorations** – 1 service per tooth surface per 24-month period.
- **Space Maintainers** – covered 1 time per lifetime on eligible Dependent children through the age of 16 for extracted primary posterior (back) teeth.
- **Brush Biopsy** – covered 1 time every 36 months for covered persons age 20 to 39, covered 1 time per 12 months for covered persons age 40 and above. (if applicable for the plan)

Endodontic Services

- **Endodontic Therapy on Primary Teeth**
  - Pulpal Therapy - covered 1 time per tooth per lifetime.
  - Therapeutic Pulpotomy - covered 1 time per tooth per lifetime.
- **Endodontic Therapy on Permanent Teeth**
  - Root Canal Therapy - covered 1 time per tooth per lifetime.
  - Root Canal Retreatment - covered 1 time per tooth per lifetime.

Periodontal Services

- **Periodontal Maintenance** – any combination of this procedure and dental cleanings (see Diagnostic and Preventive section) is covered 2 times per calendar year.
- **Periodontal scaling & root planing** – covered 1 time per 36 months if the tooth has a pocket depth of 4 millimeters or greater.
- **Full mouth debridement** – covered 1 time per lifetime.
- **Complex Surgical Periodontal Care** – The following services are considered complex surgical periodontal services under the Evidence of Coverage. Only 1 complex surgical periodontal service is covered per 36-month period.
  - Gingivectomy/gingivoplasty
  - Gingival flap
  - Apically positioned flap
  - Osseous surgery
  - Bone replacement graft
  - Pedicle soft tissue graft
  - Free soft tissue graft
  - Subepithelial connective tissue graft
  - Soft tissue allograft
  - Combined connective tissue and double pedicle graft
  - Distal/proximal wedge - covered on natural teeth only

Oral Surgery Services

- **Complex Surgical Extractions** – Surgical removal of 3rd molars are only covered if the removal is associated with symptoms or oral pathology.
- **Other Complex Surgical Procedures** – the following are covered only when required to prepare for dentures and is a benefit covered once in a 60-month period:
  - Alveoloplasty
  - Vestibuloplasty
  - Removal of exostosis-per site
  - Surgical reduction of osseous tuberosity
- **Surgical Reduction of Fibrous Tuberosity** – covered 1 time per 6-months.
- **Intravenous Conscious Sedation, IV Sedation and General Anesthesia** – covered when performed in conjunction with complex surgical services; will not be covered when performed with non-surgical dental care.
- **Temporomandibular Joint Disorder (TMJ)** – Dental treatment that is considered surgical and nonsurgical treatment of temporomandibular joint disorder (TMJ) and craniomandibular disorder, including splints. A pretreatment estimate is recommended. NOTE: If you or your dependents currently have medical insurance coverage, the claim must be first submitted to that medical insurance program. Any remaining costs after consideration under your medical insurance may be submitted to us for further benefit consideration. You must submit a copy of the medical Explanation of Benefits (EOB) along with your claim to us. If you or your dependents are not eligible for TMJ benefits under another insurance program, either medical or dental, dental services for TMJ will be covered under the Evidence of Coverage within the noted limitations, maximums, deductibles and coverage percentages.

Please note:

1. Reconstructive surgery benefits will be provided for reconstructive surgery when such dental procedures are incidental to or follow surgery resulting from injury, illness or other diseases of the involved part, or when such dental procedure is performed on a covered dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician.
2. Dental orthodontic treatment not related to the management of the congenital condition of cleft lip and cleft palate is not covered.

Major Restorative Services

- **Gold foil restorations** – Receive an amalgam (silver filling) benefit equal to the same number of surfaces and allowances, covered 1 time per 24-month period.
- **Inlays** – Benefit will equal an amalgam (silver) restoration for the same number of surfaces.
- **Pre-fabricated or Stainless Steel Crown** – covered 1 time per 60-month period for eligible Dependent children through the age of 18.
- **Onlays and/or Permanent Crowns** – covered 1 time per 7-year period per tooth for covered persons age 12 and older.
- **Recement Inlay, Onlay and Crowns** – covered 6 months after initial placement.
- **Crown Repair** – covered 1 time per 12-month period per tooth.
- **Restorative cast post and core build-up, including 1 post per tooth and 1 pin per surface** – covered 1 time per 7 year period.

Prosthodontic Services

- **Tissue Conditioning** – covered 1 time per 24-month period.
- **Reline and Rebase** – covered 1 per 24-month period after 6 months from initial placement.
- **Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s)** – covered 1 per 6-month period after 6 months from initial placement.
- **Denture Adjustments** – covered 2 times per 12-month period after 6 months following initial placement.
- **Partial and Bridge Adjustments** – covered 2 times per 24-month period after 6 months from initial placement.
- **Removable Prosthetic Services (Dentures and Partials)** – covered 1 time per 7-year period for covered persons age 16 or older.
- **Fixed Prosthetic Services (Bridge)** – covered 1 time per 7-year period for covered persons age 16 or older.
- **Recement Fixed Prosthetic** – covered 1 time per 12 months.
- **Single Tooth Implant Body, Abutment and Crown** – covered 1 time per 7-year period for covered persons age 16 and over.

Exclusions - Medical plans

This list includes services not covered under the basic provisions of these plans:

- Acupuncture
- Allergy tests and treatment, except as described in the Evidence of Coverage
- Alternative or complementary medicine
- Artificial and mechanical hearts
- Artificial insemination, fertilization, infertility drugs or sterilization reversal
- Bariatric surgery
- Benefits covered by Medicare or a governmental program
- Breast reduction or augmentation mammoplasty is excluded unless associated with breast reconstruction surgery following a medically necessary mastectomy resulting from cancer
- Care provided by a member of your family
- Care received in an emergency room that is not emergency care, except as specified in the Evidence of Coverage
- Charges incurred prior to the effective date of coverage or after the termination date of coverage
- Charges greater than the maximum allowable amount (charges exceeding the amount HealthKeepers recognizes for services)
- Comfort and/or convenience items
- Cosmetic surgery and/or treatment that's primarily intended to improve your appearance
- Dental, except as described in the Evidence of Coverage
- Drugs that are consumed or administered at the place where they are dispensed, except as described in the Evidence of Coverage
- Educational services, except as mandated
- Elective abortions
- Experimental or investigative treatment or prescription drugs not approved by the FDA
- Gynecomastia
- Non-chemical addictions such as gambling, spending, religious
- Non-skilled in sub-acute settings or custodial care
- Nutritional and dietary supplements
- Over-the-counter drugs, devices or products, except as described in the Evidence of Coverage
- Routine foot care, corrective shoes and shoe inserts
- Sclerotherapy (a medical procedure used to eliminate varicose veins and spider veins)
- Services related to the military, war, civil disobedience or resulting from participation in a felony
- Services we determine aren't medically necessary
- Sex transformation surgery
- Travel or transportation, except by professional ambulance services when medically necessary as described in the Evidence of Coverage
- Treatment for illnesses or injuries resulting from complications from non-covered services
- Vision, except as described in the Evidence of Coverage
- Weight loss programs or treatment of obesity, except as mandated
- Workers' compensation

Exclusions – Anthem dental pediatric embedded plan

We will not pay for services incurred for, or in connection with, any of the items below:

- Dental care for covered persons age 19 and older. Members turning 19 will receive the benefits listed in the pediatric dental Essential Health Benefits to the end of the month in which they turn 19.
- Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, and gnathologic recordings.
- Athletic mouth guards, enamel microabrasion and odontoplasty.
- Bacteriologic tests.
- Cytology sample collection.
- Services for the replacement of an existing partial denture with a bridge.
- Additional, elective or enhanced prosthodontic procedures including connector bar(s), stress breakers and precision attachments.
- Placement or removal of sedative filling, base or liner used under a restoration when it is billed separately from a restoration procedure.
- Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital.
- Temporomandibular Joint Disorder (TMJ).
- Repair or replacement of lost/broken appliances are not a covered service.
- Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
- Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.

Exclusions – Anthem dental pediatric, family and family enhanced plans

We will not pay for services incurred for, or in connection with, any of the items below.

- Dental care for covered persons age 19 and older. Members turning 19 will receive the benefits listed in the pediatric dental Essential Health Benefits to the end of the month in which they turn 19.
- Dental services which a covered person would be entitled to receive without charge if this coverage were not in force under any Worker's Compensation Law, or Federal Veteran's Administration program. However, if a covered person receives a bill or direct charge for dental services under any governmental program, then this exclusion shall not apply. Benefits under the Evidence of Coverage will not be reduced or denied because dental services are rendered to a policyholder or dependent that is eligible for or receiving medical assistance.
- Dental services or health care services not specifically covered under the Evidence of Coverage (including any hospital charges, prescription drug charges and dental services or supplies that are medical in nature).
- New, experimental or investigational dental techniques or services may be denied until there is, to our satisfaction, an established scientific basis for recommendation.
- Dental services completed prior to the date the covered person became eligible for coverage.
- Services of anesthesiologists.

- Intravenous and non-intravenous conscious sedation, analgesia, and general anesthesia not covered when given separate from a covered oral surgery service.
- Dental services performed other than by a licensed dentist, licensed physician, his or her employees.
- Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, and gnathologic recordings.
- Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes tooth whitening agents or tooth bonding and veneer covering of the teeth.
- Athletic mouth guards, enamel microabrasion and odontoplasty.
- Additional treatment necessary to correct or relieve the results of treatment previously benefited under the Evidence of Coverage.
- Bacteriologic tests.
- Cytology sample collection.
- Separate services billed when they are an inherent component of another covered service.
- Services for the replacement of an existing partial denture with a bridge.
- Additional, elective or enhanced prosthodontic procedures including connector bar(s), stress breakers and precision attachments.
- Placement or removal of sedative filling, base or liner used under a restoration when it is billed separately from a restoration procedure.
- Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital.
- Temporomandibular Joint Disorder (TMJ).
- Repair or replacement of lost/broken appliances are not a covered service.
- Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
- Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.

The following exclusions apply to members age 19 and older (Members turning 19 will receive the benefits listed in the pediatric dental essential health benefits to the end of the month in which they turn 19.):

- Any material grafted onto bone or soft tissue, including procedures necessary for guided tissue regeneration.
- Initial installation of an implant(s), full or partial dentures or fixed bridgework to replace a tooth (teeth) which was extracted prior to becoming a covered person under the Evidence of Coverage. EXCEPTION: This exclusion will not apply for any person who has been continuously covered for more than 24 months.
- Dental implant maintenance or repair to an implant or implant abutment.
- Surgical repositioning of teeth.
- Occlusal procedures.
- Orthodontic services.
- Retreatment of endodontic services that have been previously been covered under the Evidence of Coverage.

Exclusions – Dental prime plans

We will not pay for services incurred for, or in connection with, any of the items below.

- Dental services which a covered person would be entitled to receive for a nominal charge or without charge if this plan were not in force under any Worker's Compensation Law, Federal Medicaid program, or Federal Veteran's Administration program. However, if a covered person receives a bill or direct charge for dental services under any governmental program, then this exclusion will not apply. Benefits under the Evidence of Coverage will not be reduced or denied because dental services are rendered to a covered person who is eligible for or receiving medical assistance.
- Dental services or health care services not specifically covered under the Evidence of Coverage (including any hospital charges, prescription drug charges and dental services or supplies that are medical in nature).
- New or unproven dental techniques or services may be denied until there is an established scientific basis for recommendation.
- Dental services performed for cosmetic purposes.
- Dental services completed prior to the date the covered person became eligible for coverage.
- Services of anesthesiologists.
- Anesthesia services, except by a dentist or by an employee of the dentist when the service is performed in his or her office and by a dentist or an employee of the dentist who is certified in their profession to provide anesthesia services.
- Analgesia, analgesic agents, anxiolysis nitrous oxide, therapeutic drug injections, medicines, or drugs for non-surgical or surgical dental care. NOTE: Intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services.
- Dental services performed other than by a licensed dentist, licensed physician, his or her employees.
- Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
- Any material grafted onto bone or soft tissue, including procedures necessary for guided tissue regeneration.
- Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes tooth whitening agents or tooth bonding and veneer covering of the teeth.
- Orthodontic treatment services.
- Case presentations, office visits and consultations.
- Incomplete, interim or temporary services.
- Initial installation of an implant(s), full or partial dentures or fixed bridgework to replace a tooth (teeth) which was extracted prior to becoming a covered person under the Evidence of Coverage. EXCEPTION: This exclusion will not apply for any person who has been continuously covered for more than 24 months.
- Corrections of congenital conditions during the first 24 months of continuous coverage under the Evidence of Coverage.
- Athletic mouth guards, enamel microabrasion and odontoplasty.
- Retreatment or additional treatment necessary to correct or relieve the results of treatment previously benefited.
- Procedures designed to enable prosthetic or restorative services to be performed such as a crown lengthening.
- Bacteriologic tests.

- Cytology sample collection.
- Separate services billed when they are an inherent component of another dental service.
- Pediatric removable or fixed prosthetic appliances (dentures, partials or bridges).
- Interim or temporary removable or fixed prosthetic appliances (dentures, partials or bridges).
- Services for the replacement of an existing partial denture with a bridge.
- Additional, elective or enhanced prosthodontic procedures including, connector bar(s), stress breakers and precision attachments.
- Provisional splinting, temporary procedures or interim stabilization.
- Placement or removal of sedative filling, base or liner used under a restoration.
- Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital.
- Oral hygiene instruction.
- Occlusal procedures.
- Any charges that exceed the maximum allowed amount.
- Pulp vitality tests.
- Adjunctive diagnostic tests.
- Diagnostic casts.
- Amalgam or composite restorations placed for preventive or cosmetic purposes.
- Incomplete root canals.
- Cone beam images.
- Anatomical crown exposure.
- Temporary anchorage devices.
- Sinus augmentation.
- Restorations placed for preventive or cosmetic purposes.
- Inlays, onlays and crowns placed for preventive or cosmetic purposes.
- Crowns and indirectly fabricated restorations (inlays and onlays) are not covered unless the tooth is damaged by decay or fracture with loss of tooth structure to the point it cannot be restored with an amalgam or resin restoration.
- Recement space maintainers.
- Consultations.
- Orthodontic services.
- Brush biopsy (if applicable for the plan).

This piece is only one part of your information kit. This piece refers to Policy form # VA_HMPSHS_(1/16). Schedule of benefits forms: VA_SB_BRZ_HMO_HSA_4000_35_(1-16), VA_SB_BRZ_HMO_POS_4100_30_35_(1-16), VA_SB_BRZ_HMO_4650_35_45_(1-16), VA_SB_BRZ_HMO_POS_HSA_5350_0_(1-16), VA_SB_BRZ_HMO_5500_25_40_(1-16), VA_SB_BRZ_HMO_HSA_6000_15_(1-16), VA_SB_BRZ_HMO_HSA_6100_50_(1-16), VA_SB_SVR_HMO_1550_30_35_(1-16), VA_SB_SVR_HMO_POS_2000_20_20_(1-16), VA_SB_SVR_HMO_2250_20_35_(1-16), VA_SB_SVR_HMO_2600_20_35_(1-16), VA_SB_SVR_HMO_3350_15_45_(1-16), VA_SB_GLD_HMO_750_20_30_(1-16), VA_SB_GLD_HMO_POS_1100_15_20_(1-16), VA_SB_CAT_HMO_6850_0_40_(1-16) and 11-10141.46 and 13-03281.46-IND 0116. This piece refers to dental policy form #'s: 11-10141.46 13-03281.46-IND 0116.

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Notes

Anthem BlueCross BlueShield

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