



Anthem[®] HealthKeepers

Individual and family health benefit plans for Virginia

**We make it easy.
Find out how.**

**Core, Essential and
Preferred plans**





Health care may never be simple, but choosing the right plan can be.

When it comes to Individual health care coverage, it's not one-size-fits-all. With HealthKeepers, Inc. (HealthKeepers), you get a wide range of options so you can compare plans and find the best coverage for your needs and budget. No one knows what you and your family need better than you. Just let us know and we're here to help when and where you need us.

To learn more about your options, review this information with your HealthKeepers authorized representative.

Total health care

We offer you a total health solution, so you can live healthier, feel better and save money doing it. With HealthKeepers, you get:

- Easy-to-use tools to find a doctor, hospital, provider or pharmacy

- No-cost preventive care, like checkups and flu shots
- 24/7 NurseLine
- Online support to manage your plan
- Reliable customer service

Network value

Access to the best doctors in your area is important. And we've created our network of doctors and hospitals with this in mind. Our goal is to work with doctors and hospitals who will offer the best care possible — at a lower cost. Our Pathway Tiered Hospital network includes:

- Doctors and hospitals
- Lab, durable medical equipment and behavioral health providers
- Urgent and emergency providers

A friendly face in a changing world

Health care is changing but one thing is clear: we're here to provide health care benefits to people like you — now and in the future. Starting in 2014, all Americans must have health coverage. In fact, you can't be turned down! You can purchase coverage direct from HealthKeepers or through your state's health insurance marketplace (also known as the Exchange). In some cases, the government may even help pay for your coverage. Get the health care coverage you need from HealthKeepers.

Get help today!

Call your HealthKeepers authorized representative or visit us online at anthem.com where you can view and compare plan options.

How Health Care Coverage Works

Health care coverage can help protect you against the high costs of care. With most health care coverage, you pay a monthly fee called a premium, then you share some of the cost of covered care with the company that provides your coverage. With HealthKeepers, you can choose the level of cost sharing that works best for your health care needs and budget.

Here's an example: *Meet John*

John's story is only an example of how health plans work. Be sure to look at the benefits for each of our plan choices for specific information.

John's health plan has the following benefits:

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

After injuring his knee in a soccer game, John calls his doctor. He chooses providers in our network, which saves him the most money. By choosing in-network providers, John gets lower negotiated rates (meaning, discounted prices). In the following examples, you'll see what John paid and why it's important to have health insurance.

Copay (Copayment)

On some plans you pay a fixed dollar amount for certain services when you get them. For example, when you see a doctor, you may be asked to pay a \$35 copay.

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

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

Deductible

You pay this amount for covered medical services each calendar year (January through December). Covered services that apply to the deductible may include lab work, X-rays, anesthesia and surgeon fees. (Covered preventive services start before the deductible is met.) Your deductible starts over each calendar year.

Please note:

For non-HSA plans, each family member has an individual deductible and out-of-pocket limit. The family deductible and out-of-pocket limit can be satisfied by two or more members. No one person can contribute more than his or her individual deductible or out-of-pocket limit. For HSA qualified plans, either one or more family members must meet the family deductible before any covered services that are subject to the deductible will be paid by the plan. The family out-of-pocket limit can be met by either one or more members. Once the limit is met, no additional coinsurance will be required for the family for the remainder of the calendar year.

Here's what happens next when John's doctor orders an approved MRI of the knee and recommends surgery:

MRI

- *MRI cost (without insurance):* \$1,500
- *HealthKeepers' negotiated rate:* \$1,000
- *What 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
- *What John paid:* \$1,000 (John's payment satisfies the remaining \$1,000 deductible.)
- *Remaining cost of surgery:* \$34,000

Coinsurance

Once you've met your deductible, HealthKeepers starts paying a portion of claims. The health care bills that remain are shared between you and HealthKeepers. Your coinsurance is the percent that you must pay for a covered service per calendar year. Having met his deductible, John's coinsurance begins.

Let's check in to see what John will be paying.

- *Coinsurance:* 30% (30% of \$34,000 = \$10,200)
- *What John paid:* \$2,965 (John's payment satisfies the remainder of his \$5,000 out-of-pocket limit.)

Out-of-pocket limit

The most you pay during a policy period before your health insurance begins to pay at 100% (of the allowed amount). The amounts you pay for your deductible, coinsurance and copay are typically what make up your out-of-pocket limit. Once you meet your out-of-pocket limit, we pay 100% (of the allowed amount) of covered services for the rest of the calendar year.

John has met his out-of-pocket and the remaining surgery costs are paid.

- *HealthKeepers pays:* \$31,035
- *Out-of-pocket limit:* \$5,000

Summary

John paid far less out-of-pocket because he had health care coverage. If John had used an out-of-network provider, depending on his plan, he might not have had coverage or would have had to pay much more.

- *Total for doctor visit, X-ray and surgery (without health insurance):* \$51,700
- *Total HealthKeepers paid after discounts:* \$31,140
- *Total John paid:* \$5,000

Covering you A to Z

All of our plan options have one major goal in mind: Making sure you stay healthy and that you get the quality care you need when you need it. That's why, no matter which plan you choose, you're covered for preventive care to emergencies, and more!

What's covered?

- ¹Preventive and wellness services and help managing a chronic (ongoing) disease
- Outpatient (ambulatory) patient care
- Emergency services, like going to the ER or urgent care
- Inpatient care (where you stay overnight in a hospital)
- Laboratory services
- Prescription drugs
- Rehabilitative and habilitative services (habilitative services help a person learn, keep or improve skills they may not be developing normally)
- Mental health and substance abuse services
- Maternity (pregnancy) and newborn care
- Pediatric services (health care for children)

Don't forget dental and vision coverage. Check out our dental and vision plans. Just call your HealthKeepers authorized representative or go online to [anthem.com](https://www.anthem.com) for details.

A closer look at prescription drug coverage

Prescription drug benefits help cover the cost of medications your doctor prescribes. We're here to help you better understand your prescription drug plan and the choices you have when it comes to selecting and paying for these medications.

To find out if your medication is covered, take a look at our drug list at [anthem.com](https://www.anthem.com) > Customer Support > Forms Library > Anthem Select Drug List. Covered medications are assigned to certain tiers (or levels) based on cost, availability and similar alternatives. By selecting a Tier 1 medication, you may have a lower cost share. You can usually save money by selecting a generic version of a medication. Or even save time by having medicine sent right to your home. Always talk to your doctor first about which medication is right for you.

Please visit our Find a Doctor tool on [anthem.com](https://www.anthem.com) to see if your pharmacy is in-network.

Access coverage – no matter where you are in the U.S. – with BlueCard®

When you're traveling for work or on vacation, going to the ER or urgent care is probably the last thing you want to happen. However, our plans cover emergency and urgent care in every state through the Blue Cross and Blue Shield Association's BlueCard® Program. This means you and your family have emergency and urgent care coverage from coast to coast.

Take care of yourself with no-cost preventive care

HealthKeepers' preventive care coverage options give you access to any of our network doctors so you pay nothing out of pocket. Stay in control of your health care and your finances with \$0 deductible, \$0 copay and \$0 cost to you for covered preventive services received in-network.

¹Preventive and wellness services consist of services recommended by the United States Preventive Services Task Force, including well-child care, immunizations, PSA screenings, Pap tests, mammograms and more.



Your plan options

We offer plans to fit your health care coverage needs — and your budget. To make it easy to compare and choose a plan, they are split into three different levels — Core, Essential and Preferred. Your costs and coverage increase with each level.

Core	With the Core plans, you pay less for your monthly premium but you pay more when you get care. You have broad benefits with deductibles, copays and coinsurance that may be higher than the other plans.
Essential	The Essential plans still have lower monthly premiums but you pay less when you get care.
Preferred	With the Preferred plan, you have richer benefits and pay less when you get care. However, the monthly premium is higher than the Core and Essential plans.

Make your health care dollars work harder with a Health Savings Account

A Health Savings Account (HSA) is a savings account that 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 your qualified health care expenses, including prescriptions. HSA-compatible health care plans work with or without this savings account, the choice is yours.

Plan choices that are HSA-compatible include HSA in the plan name. Check with your tax advisor to see if an HSA plan is right for you and check out the insert from our preferred banking partner.

What doctors can I see?

The health care plans we offer are **DirectAccess** plans. With this type of plan, you have the freedom to see any in-network doctor you choose. It's also a good idea to have a primary care physician (PCP) for things like checkups and health issues that need ongoing care. However, you're not required to select a PCP.

What is an in-network provider?

When you need care, you will get the best value by visiting an **in-network** doctor, hospital or other health care provider. **In-network** (or participating) refers to doctors, hospitals and other health care providers that have agreed to accept lower negotiated rates (discounted prices) for their covered services. These agreed upon rates can help lower the cost of covered health care services, including your share of the costs. This is true when you're paying the whole cost for covered services (such as while you are meeting your deductible). And it's also true when we are sharing the cost (while you are meeting your out-of-pocket limit).

Out-of-network (or nonparticipating) refers to doctors, hospitals and other health care providers that are not contracted with your health plan to provide services at a negotiated rate. Our plans do not offer out-of-network benefits (with the exception of emergency and urgent care). This means you will pay the entire cost for any service you get from **out-of-network** providers.

To find out if your current health care provider is in our network, visit our Find a Doctor tool on anthem.com.

What is a tiered network?

Most of our plans include a tiered network. In-network hospitals are split into two categories, Tier 1 and Tier 2. You'll pay a lower cost share for hospitals in Tier 1. You can find out what tier a hospital is in through our Find a Doctor tool at anthem.com.

Easy-to-use online tools

HealthKeepers' website is an easy-to-use resource that allows you to manage your health care in a simple and convenient way. With our website, you can:

- Find out what is and isn't covered by your plan with an easy-to-understand breakdown of your benefits summary.
- Get instant access to your recent claims and coverage details.
- Know your costs before having certain procedures with clear estimates using our out-of-pocket cost calculator.

Get help from nurses 24/7

HealthKeepers' 24/7 NurseLine gives you access to trained registered nurses any time of the day or night for answers to your general health questions, to help you understand your symptoms and to help you determine the right care at the right time.

Find a Doctor

Want to make sure your doctor is in our network? Need to find a new doctor or specialist? No problem! Our online Find a Doctor Tool helps you find doctors, hospitals, pharmacies and other specialists in your area — and shows whether they are cost-saving network providers. Log on to anthem.com anytime or download our mobile app right to your phone, so you can search for doctors when you're on the go.

Zagat® Health Survey

It's similar to the restaurant survey. See what other patients have said about the doctors and hospitals you're thinking about using. Add your own doctor reviews, too!

Access cost and quality information with Estimate Your Cost

Save time and money by comparing the cost of common procedures at health care facilities in your area. You'll also get to compare quality and safety.

Save time and money with an urgent care center or retail health clinic

You can save money — and usually lots of time — by going to places other than the emergency room (ER) when your condition is not an emergency. The Find a Doctor tool can help find alternatives to the ER like urgent care centers, walk-in doctor's offices and retail health clinics.



Tips for picking a health plan

Choosing the right health care coverage is an important decision. Before you choose a plan, consider these tips. And remember, your HealthKeepers authorized representative is here to answer any questions.

- **Make sure the plan will meet your health care coverage needs.** Think about how often you see doctors and specialists. What prescription medications do you take?
- **If staying with your current doctors is important,** see if they're in our network by using our online Find a Doctor tool at anthem.com. Seeing an in-network doctor can save you a lot of money on your health care.
- **Figure out your family's budget for coverage.** Some people would prefer to pay more in premium each month and less out of pocket each time for services like doctors' visits or lab work. Plans may offer different deductible, coinsurance and copay options so you can choose the level of cost sharing that best meets your health care coverage needs and budget.
- **Consider making contributions to a Health Savings Account (HSA).** Making post-tax contributions to an HSA can help make your money go further. Talk to your financial advisor about potential tax advantages.

Do I qualify to get help paying for my health insurance?

Before you choose a plan, it's a good idea to find out if you qualify to get help paying for your health insurance. If you do qualify, it may make more sense for you to choose an Anthem HealthKeepers plan available through the Health Insurance Marketplace. Whether you choose an Anthem HealthKeepers plan offered through the Health Insurance Marketplace or direct through HealthKeepers, we have great plan options for you.

When can I purchase a plan?

Plans can be purchased once a year through an open enrollment period. This year, open enrollment is from October 1, 2013, to December 15, 2013 for a January 1, 2014 effective date. You may also enroll from December 16, 2013 through March 31, 2014 for effective dates after January 1, 2014. Check with your HealthKeepers authorized representative for effective date options and guidelines around enrollment during other times of the year.

How do I enroll in an Anthem HealthKeepers plan?

- If you are ready to enroll or would like more information about the health care plans offered by HealthKeepers, call your HealthKeepers authorized representative today!
- Visit our website at anthem.com and apply online.



Anthem HealthKeepers

Get help today!

Call your HealthKeepers authorized representative or visit us online at anthem.com where you can view and compare plan options.

We want you to be satisfied

After you enroll in a plan offered by HealthKeepers you will receive a contract known as the Evidence of Coverage that explains the exact terms and conditions of coverage, including the plan's exclusions and limitations. You will have 10 days to examine your plan's features. During that time, if you are not fully satisfied, you may cancel your policy and your premiums will be refunded, less 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 plan/policy may be continued in force or discontinued. For more complete details, including what's covered and what isn't:

- See the coverage details document included with this brochure.
- Call your HealthKeepers authorized representative.
- Go to anthem.com.

For more information on how to access a Summary of Benefits and Coverage (SBC), please visit www.healthcare.gov and enter SBC in the search field.

The health plans described within this document are not eligible for a premium tax credit subsidy.

A high deductible health plan is not a health savings account (HSA). An HSA is a separate arrangement between an individual and a qualified financial institution. To take advantage of tax benefits, an HSA needs to be established. This brochure provides general information only and is not intended to be a substitute for the advice of a qualified tax professional.

ACS|BNY Mellon is an independent corporate entity that provides banking administration on behalf of HealthKeepers.

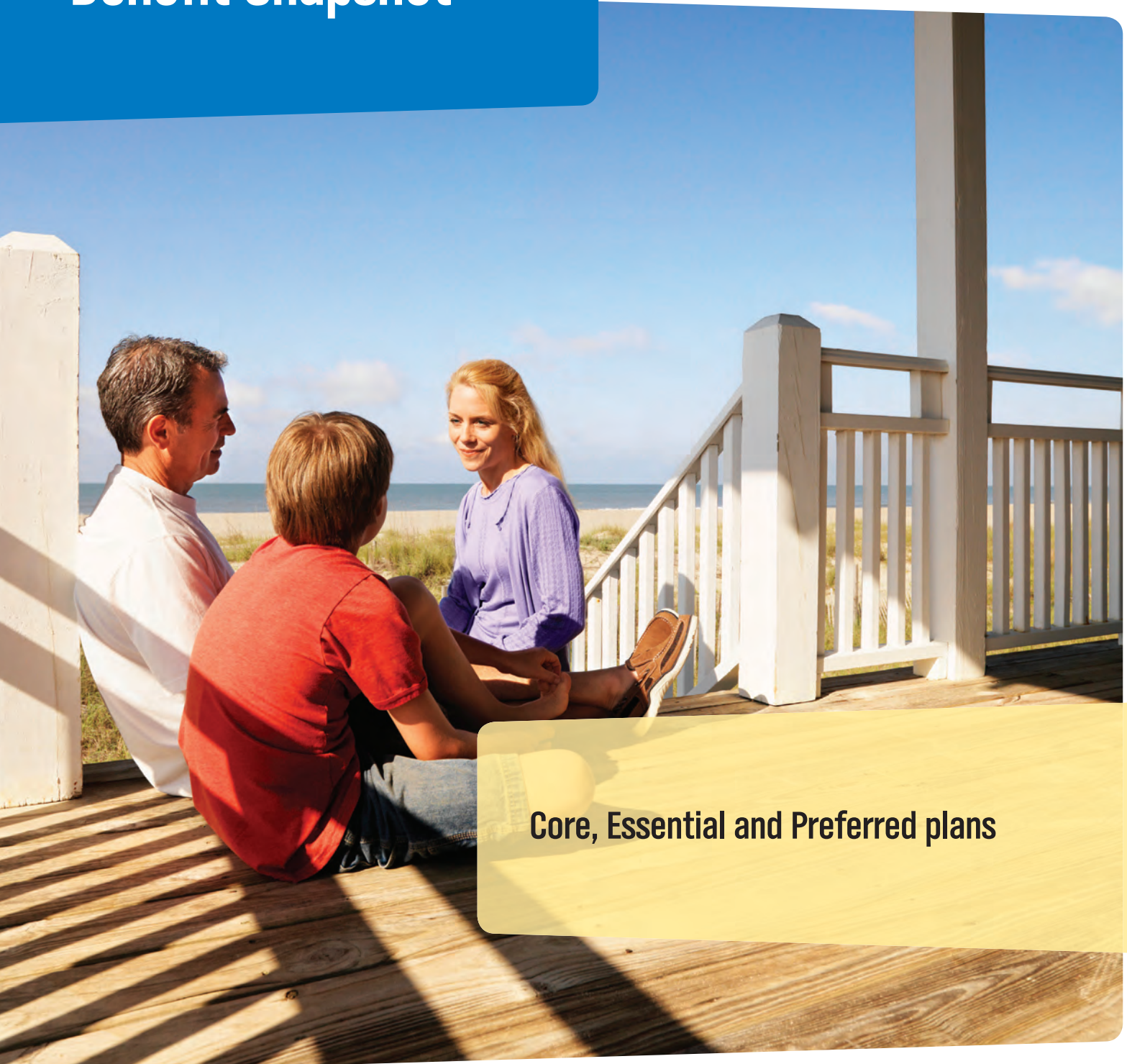
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Anthem HealthKeepers

Individual and family health benefit plans for Virginia

Benefit Snapshot



Core, Essential and Preferred plans

Benefit Snapshot

Below is a listing of our plan choices, including a sample of commonly used benefits and how they are covered under each plan. Each plan name has a unique four-letter code at the end. When filling out an application, make sure the entire plan name on the application (including the four letters) matches the plan you want to apply for.

If you need more information about a certain benefit that is not listed here, please check with your HealthKeepers, Inc. (HealthKeepers) authorized representative. You can also view and compare plans on [anthem.com](https://www.anthem.com).

Plan Name	Network Name	Calendar Year Deductible		Calendar Year Out-of-pocket Limit		Office Visit: Primary Care Doctor	Preventive Care	Retail Prescription Drug Coverage			
		Individual	Family	Individual	Family			Tier 1	Tier 2	Tier 3	Tier 4
Anthem HealthKeepers Core DirectAccess with HSA - cacd	Pathway Tiered Hospital	\$3,750	\$7,500	\$6,200	\$12,400	25% coinsurance	No cost to you	Deductible and 25% coinsurance applies	Deductible and 25% coinsurance applies	Deductible and 25% coinsurance applies	Deductible and 25% coinsurance applies
Anthem HealthKeepers Core DirectAccess - cabw	Pathway Tiered Hospital	\$4,500	\$9,000	\$6,350	\$12,700	\$35 copay per visit for first 3 office visits, then deductible and 35% coinsurance applies	No cost to you	Deductible and 35% coinsurance applies	Deductible and 35% coinsurance applies	Deductible and 35% coinsurance applies	Deductible and 35% coinsurance applies
Anthem HealthKeepers Core DirectAccess with Child Dental - cdbw	Pathway Tiered Hospital	\$4,500	\$9,000	\$6,350	\$12,700	\$35 copay per visit for first 3 office visits, then deductible and 35% coinsurance applies	No cost to you	Deductible and 35% coinsurance applies	Deductible and 35% coinsurance applies	Deductible and 35% coinsurance applies	Deductible and 35% coinsurance applies
Anthem HealthKeepers Core DirectAccess - caam	Pathway Tiered Hospital	\$5,500	\$11,000	\$6,350	\$12,700	\$40 copay per visit for first 2 office visits, then deductible and 25% coinsurance applies	No cost to you	Deductible and 25% coinsurance applies	Deductible and 25% coinsurance applies	Deductible and 25% coinsurance applies	Deductible and 25% coinsurance applies
Anthem HealthKeepers Core DirectAccess with HSA - caas	Pathway Tiered Hospital	\$6,000	\$12,000	\$6,350	\$12,700	15% coinsurance	No cost to you	Deductible and 15% coinsurance applies	Deductible and 15% coinsurance applies	Deductible and 15% coinsurance applies	Deductible and 15% coinsurance applies
Anthem HealthKeepers Essential DirectAccess - cbky	Pathway Tiered Hospital	\$1,500	\$3,000	\$5,500	\$11,000	\$35 copay per visit for first 3 office visits, then deductible and 30% coinsurance applies	No cost to you	\$15 copay	\$40 copay	Deductible and 30% coinsurance applies	Deductible and 30% coinsurance applies
Anthem HealthKeepers Essential DirectAccess - cbjs	Pathway Tiered Hospital	\$2,250	\$4,500	\$6,350	\$12,700	\$35 copay, unlimited	No cost to you	\$15 copay	\$40 copay	Deductible and 20% coinsurance applies	Deductible and 20% coinsurance applies
Anthem HealthKeepers Essential DirectAccess - cbfs	Pathway Tiered Hospital	\$2,600	\$5,200	\$6,000	\$12,000	\$35 copay per visit for first 3 office visits, then deductible and 20% coinsurance applies	No cost to you	\$15 copay	\$40 copay	Deductible and 20% coinsurance applies	Deductible and 20% coinsurance applies
Anthem HealthKeepers Essential DirectAccess - cbau	Pathway Tiered Hospital	\$3,350	\$6,700	\$5,500	\$11,000	\$45 copay, unlimited	No cost to you	\$15 copay	\$40 copay	Deductible and 15% coinsurance applies	Deductible and 15% coinsurance applies
Anthem HealthKeepers Preferred DirectAccess - ccam	Pathway Tiered Hospital	\$750	\$1,500	\$3,500	\$7,000	\$30 copay, unlimited	No cost to you	\$15 copay	\$40 copay	Deductible and 20% coinsurance applies	Deductible and 20% coinsurance applies
Anthem HealthKeepers Preferred DirectAccess with Child Dental - cdda	Pathway Tiered Hospital	\$750	\$1,500	\$3,500	\$7,000	\$30 copay, unlimited	No cost to you	\$15 copay	\$40 copay	Deductible and 20% coinsurance applies	Deductible and 20% coinsurance applies

Preventive care services consist of services recommended by the United States Preventive Services Task Force, including well-child care, immunizations, PSA screenings, Pap tests, mammograms and more.

Tiered hospitals: Our plans offer a Tiered network. In-network hospitals are split into two categories, Tier 1 and Tier 2. You will pay a lower cost share for hospitals in Tier 1. You can find out what tier a hospital is in through our Find a Doctor tool at [anthem.com](https://www.anthem.com).

Emergency room services have a higher cost share. For additional details on this and other covered services, go to [anthem.com](https://www.anthem.com)

All plans available with optional bariatric surgery coverage for an additional premium. For more information contact your HealthKeepers authorized representative.



Anthem[®] HealthKeepers

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This piece is only one part of your information kit. This piece refers to Policy form # VA_HMHS(1/14). Schedule of benefits forms VA_SB_BRZ_3750_ORUT_(1/14), VA_SB_BRZ_4500_ORUR_(1/14), VA_SB_BRZ_4500_PD_ORV3_(1/14), VA_SB_BRZ_5500_ORUM_(1/14), VA_SB_BRZ_6000_ORUP_(1/14), VA_SB_SLV_1500_ORVN_(1/14), VA_SB_SLV_2250_ORVH_(1/14), VA_SB_SLV_2600_ORVC_(1/14), VA_SB_SLV_3350_ORV7_(1/14), VA_SB_GLD_750_ORWD_(1/14), VA_SB_GLD_750_PD_ORWH_(1/14) and rider form VA_Bariatric_(1/14).



Your HSA: Convenience, savings and flexibility all rolled into one

Introducing BenefitWallet™: A Xerox solution from BNY | Mellon

Setting up a Health Savings Account (HSA)

To realize your plan's full financial power, consider selecting a plan with an HSA account. The portability and tax savings of an HSA account can add up fast.

We've joined with The Bank of New York Mellon (BNY Mellon) to integrate its HSA Solution, BenefitWallet™, into a selection of our plans. Setting up your account with BNY Mellon is easy. Plus, it comes with built-in advantages and conveniences like:

- A single Customer Service contact for the health plan and your HSA
- A single online health site to access your plan benefit information and account details
- Several payment and deposit options, including special checks and automatic fund transfers
- Competitive interest rates and investment opportunities for the funds in your account
- Mobile account access from iPhone®, iPad® and Android™ devices
- Health Topics encyclopedia of more than 1,500 ailments
- Medication Advisor for drugs and pharmacy identifier
- Treatment Cost Advisor for common medical conditions

Of course, if you'd rather use another financial institution for your account, that's fine, too.



You're only one checkmark away

Simply make the selection on your application form. We'll take care of setting up your account. We'll also take care of sending you a *Welcome Kit* to get you started. All you have to take care of is your health. Which is, after all, the most important thing.

A closer look

HSA Welcome Kit

If you make the selection on your application form, your HSA will automatically be set up — no set-up fee required, and you'll soon receive an HSA Welcome Kit. In it, you'll find all of the banking documentation and instructions for using your account. A separate application for your account is only required if you choose a financial institution other than BNY Mellon.

Interest and investments

You'll earn interest on your HSA funds and have the chance to invest your funds as long as you keep a minimum \$1,000 HSA balance. Investment options include a number of mutual families. Once you're ready to invest, just call the ACS|BNY Mellon HSA Solution Contact Center at **866-686-4798**, Monday through Friday, from 8 a.m. to 8 p.m. ET, for a prospectus with more details.

Debit cards, checkbooks and online banking

Use your MasterCard® debit card, your HSA checkbook, or our new online banking option (provided by BNY Mellon) to pay your health care provider or pharmacy directly for eligible medical expenses — or to get cash from your account.

Deposits to your account

To contribute to your HSA, simply send a check and deposit slip to the address printed on your HSA checkbook. Or, you can set up an electronic funds transfer between your bank and BNY Mellon for regular account contributions.

Account activity statements

Each month, you'll receive a statement from BNY Mellon that shows all your account activity. For an additional fee of \$1.25 per month, you can receive a paper statement. Please go to anthem.com or call your dedicated Customer Service line to learn how to elect this option. You'll also receive IRS 1099 and IRS 5498 forms from BNY Mellon near tax time to help with tax preparation.

BenefitWallet™ HSA fee and rate schedule

A Deposit Agreement and a Disclosures and Fee Sheet will be in your HSA Welcome Kit. Please refer to those documents for the complete terms and conditions related to your account.

As good as these options may sound, you should still talk to your tax advisor when trying to maximize financial benefits for your personal situation.

Banking fees	
Monthly account fee	\$2.95
First two debit cards	no charge
Debit card transactions	
Check writing	
ATM transactions	\$2
Card replacement	\$5
Duplicate check	
Check reorder	\$10
Nonsufficient funds	\$25
Stop-check service	\$25
Periodic paper statement	\$1.25

This is what the IRS requires if you want to open a Health Savings Account:

- You must be covered by an HSA-compatible, high-deductible health plan.
- You must be a U.S. resident, and not a resident of Puerto Rico or American Samoa.
- You cannot be covered by any other medical plan that is not an HSA-compatible, high-deductible health plan.
- You cannot be enrolled in Medicare.
- You cannot be claimed as a dependent on another individual's tax return.
- If you are a veteran, you may not have received veteran's benefits within the last three months.
- You cannot be active military.

Coverage Details for Virginia



Anthem HealthKeepers

Things you need to know before you buy...

***Anthem HealthKeepers Core DirectAccess, Anthem HealthKeepers Core DirectAccess with Child Dental, Anthem HealthKeepers Core DirectAccess with HSA, Anthem HealthKeepers Essential DirectAccess, Anthem HealthKeepers Preferred DirectAccess, Anthem HealthKeepers Preferred DirectAccess with Child Dental, Anthem HealthKeepers Catastrophic DirectAccess**

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

Eligibility

Subscriber

To be eligible for membership as a subscriber under your Evidence of Coverage, the applicant must:

1. Be a United States citizen or national; or
2. Be a lawfully present non-citizen for the entire period for which coverage is sought; and
3. Be a legal resident of Virginia;
4. Be under age 65;
5. Submit proof satisfactory to HealthKeepers, Inc. (HealthKeepers) to confirm dependent eligibility;
6. Agree to pay for the cost of premium that HealthKeepers requires;
7. Reveal any coordination of benefits arrangements or other health benefit arrangements for the applicant or dependents as they become effective;
8. Not be incarcerated (except pending disposition of charges);
9. Not be entitled to or enrolled in Medicare Parts A/B and/or D;
10. Not be covered by any other group or individual health benefit plan.

For purposes of eligibility, the service area is the area in which you:

1. Reside, intend to reside (including without a fixed address); or
2. The area in which you are seeking employment (whether or not currently employed); or
3. Have entered without a job commitment.

Dependents

To be eligible for coverage to enroll as a dependent, you must be listed on the enrollment form completed by the subscriber, meet all dependent eligibility criteria and be:

1. The subscriber's legal spouse.
2. The subscriber's domestic partner as determined eligible by the Exchange.
3. The subscriber's or the subscriber's spouse's children, including stepchildren, newborn and legally adopted children under age 26.
4. Children under age 26 for whom the subscriber or the subscriber's spouse is a legal guardian.

Eligibility will be continued past the age limit only for those already enrolled dependents who cannot work to support themselves by reason of intellectual or physical disability. These dependents must be allowed as a federal tax exemption by the subscriber or subscriber's spouse. The dependent's disability must start before the end of the period he or she would become ineligible for coverage. The Plan must certify the dependent's eligibility. The Plan must be informed of the dependent's eligibility for continuation of coverage within 30 days after the dependent would normally become ineligible. You must notify us if the dependent's tax exemption status changes and if he or she is no longer eligible for continued coverage.

The Plan may require the subscriber to submit proof of continued eligibility for any enrolled child. Your failure to provide this information could result in termination of a child's coverage.

Temporary custody is not sufficient to establish eligibility under your Evidence of Coverage.

Any foster child who is eligible for benefits provided by any governmental program or law will not be eligible for coverage under your Evidence of Coverage unless required by the laws of this State.

Open Enrollment

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

Effective dates for open enrollment period:

The earliest effective date for the annual open enrollment period is the first day of the following benefit calendar year - if not defined. The actual effective date is determined by the date we receive a complete application with the applicable premium payment. Effective date for the annual open enrollment period is the first day of the following month if receipt of application and premium is between the 1st and 15th of the month. If receipt of application and premium is after the 15th of the month, your effective date will be the first day of the month following plus one additional month (example: application with premium receipt is January 20, your effective date is March 1).

Special Enrollment

A special enrollment period is a period during which a member or an enrollee who experiences certain qualifying events or changes in eligibility may enroll in a plan, outside of the annual open enrollment period.

Anthem HealthKeepers Core DirectAccess, Anthem HealthKeepers Core DirectAccess with Child Dental, Anthem HealthKeepers Core DirectAccess with HSA, Anthem HealthKeepers Essential DirectAccess, Anthem HealthKeepers Preferred DirectAccess, Anthem HealthKeepers Preferred DirectAccess with Child Dental, Anthem HealthKeepers Catastrophic DirectAccess

Length of special enrollment periods: Unless specifically stated otherwise, an individual or enrollee has 60 calendar days from the date of a qualifying event to select a plan.

Qualifying Events:

- Involuntary loss of minimum essential coverage for any reason other than fraud, intentional misrepresentation of a material fact or failure to pay premium;
- Loss of minimum essential coverage due to dissolution of marriage;
- Marriage;
- Adoption or placement for adoption; and
- Birth.

Newborn and Adopted Child Coverage

A newborn dependent may be covered from the moment of birth and a dependent placed with you for adoption is covered from the date of placement. Coverage for newborns will continue beyond the 31 days, provided the subscriber with other than family coverage submits through the Plan a form to add the child under the subscriber's Evidence of Coverage. The form must be submitted along with the additional premium, if applicable, within 60 days after the birth of the child. Failure to notify the Plan and pay any applicable premium during this 31 day period will result in no coverage for the newborn or adopted child beyond the first 31 days. A child will be considered adopted from the earlier of: (1) the moment of placement for adoption; or (2) the date of an entry of an order granting custody of the child to you. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption.

Adding a Child due to Award of Guardianship

If a subscriber or the subscriber's spouse files an application for an appointment of guardianship for a child, an application to cover the child under the subscriber's Evidence of Coverage must be submitted to HealthKeepers within 60 days of the date of the appointment of guardianship. Coverage will be effective on the date the appointment of guardianship is awarded by the court.

Qualified Medical Child Support Order

If you are required by a Qualified Medical Child Support Order or court order, as defined by applicable state or federal law, to enroll your child under your Evidence of Coverage, and the child is otherwise eligible for the coverage, HealthKeepers will permit your child to enroll under your Evidence of Coverage, and we will provide the benefits of your Evidence of Coverage in accordance with the applicable requirements of such order.

A child's coverage under this provision will not extend beyond any dependent age limit. Any claims payable under your Evidence of Coverage will be paid, at HealthKeepers' discretion, to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial

parent, or legal guardian. We will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to us directly.

Effective Date of Coverage

The earliest effective date for the annual open enrollment period is the first day of the following benefit calendar year - if not defined. The actual effective date is determined by the date we receive a complete application with the applicable premium payment. Effective date for the annual open enrollment period is the first day of the following month if receipt of application and premium is between the 1st and 15th of the month. If receipt of application and premium is after the 15th of the month, your effective date will be the first day of the month following plus one additional month (example: application with premium receipt is January 20, your effective date is March 1).

Effective dates for special enrollment periods:

1. In the case of birth, adoption or placement for adoption, coverage is effective on the date of birth, adoption, or placement for adoption; and
2. In the case of marriage, or in the case where an individual loses minimum essential coverage, coverage is effective on the first day of the following month after your application is received.

Effective dates for loss of minimum essential coverage includes loss of eligibility for coverage as a result of:

1. Legal separation or divorce;
2. Cessation of dependent status, such as attaining the maximum age;
3. Death of an employee;
4. Termination of employment;
5. Reduction in the number of hours of employment; or
6. Any loss of eligibility for coverage for any of the following:
 - Individual who no longer resides, lives or works in the Plan's service area,
 - A situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits,
 - A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual,
 - Termination of employer contributions, and
 - Exhaustion of COBRA benefits.

Effective dates for loss of minimum essential coverage does not include termination or loss due to:

1. Failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or
2. Situations allowing for a rescission such as fraud or intentional misrepresentation of material fact.

Anthem HealthKeepers Core DirectAccess, Anthem HealthKeepers Core DirectAccess with Child Dental, Anthem HealthKeepers Core DirectAccess with HSA, Anthem HealthKeepers Essential DirectAccess, Anthem HealthKeepers Preferred DirectAccess, Anthem HealthKeepers Preferred DirectAccess with Child Dental, Anthem HealthKeepers Catastrophic DirectAccess

Guaranteed Renewable

Coverage under your Evidence of Coverage is guaranteed renewable at your discretion. You may renew your Evidence of Coverage by payment of the renewal premium by the end of the grace period of the premium due date, provided the following requirements are satisfied:

1. Eligibility criteria continues to be met;
2. There are no fraudulent or intentional misrepresentations of material fact on the application or under the terms of this coverage, subject to the incontestability provision;
3. Membership has not been terminated by HealthKeepers under the terms of your Evidence of Coverage; and
4. Membership has not been rescinded by HealthKeepers.

HMO Providers

An HMO is a medical group, HMO physician, hospital, skilled nursing facility, pharmacy, or any other duly licensed institution or health professional who has Evidence of Coverage with the HMO or its designee to provide covered services to members. A list of HMO providers is made available to each subscriber prior to enrollment. A current list may be obtained from the HMO upon request and may be seen by visiting the HMO's website page at anthem.com. The list shall be revised by the HMO from time to time as the HMO deems necessary.

How to Find a Provider in the Network

There are three ways you can find out if a provider or facility is in the network for this Plan. You can also find out where they are located and details about their license or training.

- See your Plan's directory of in-network providers at anthem.com, which lists the doctors, providers, and facilities that participate in this Plan's network.
- Call Customer Service to ask for a list of doctors and providers that participate in this Plan's network, based on specialty and geographic area.
- Check with your doctor or provider.

If you need help choosing a doctor who is right for you, call the Customer Service number on the back of your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

Tier 1 and Tier 2 Hospitals

We have designated certain hospitals as participating in Tier 1 or Tier 2. Tier 1 hospitals have lower costs to the member. Tier 2 hospitals are more costly. While these hospitals are contracted with us, we make no representation on the relative quality of the services. When a member goes to an out-of-network hospital, there is no agreement on the cost of the service and the member is responsible for the entire amount the provider charges.

Below are examples of what criteria is used to determine whether a hospital was allocated to Tier 1 or Tier 2. In communities where there was only one hospital, these hospitals were allocated to Tier 1:

- Total share of payments by region of the Commonwealth
- The number of admissions per hospital and region
- The average length of stay per hospital
- The percentage of admissions over our contractual threshold
- The current case mix adjusted case rate by hospital and by region.
- The effective hospital discount inclusive of patient pay
- The percentage of claims paid on stop loss by hospital and hospital system
- The average charge increase by hospital and hospital system
- The hospital efficiency ratio based on Virginia Health Information reported actual length of stay divided by expected length of stay.

Outpatient Hospital Services

These are services provided in the hospital's outpatient department, or, if medically necessary, in the hospital's emergency room. We cover:

- Services and supplies used to diagnose or treat injuries resulting from an accident (including follow-up care);
- Services and supplies used to diagnose or treat the sudden onset of a severe emergency medical condition; and
- Services and supplies related to, and provided at the same time as a covered outpatient surgical services. Examples include:
 1. Anesthesia and its related supplies; and
 2. Operating and recovery room use.

Outpatient Care for an Inpatient from another Hospital

The ancillary services listed under the Inpatient Hospital Services provision of this section are covered at a different hospital location if the facility where you are an inpatient cannot provide the medically necessary service you need.

Requesting Approval for Benefits

To receive full benefits for covered inpatient hospitalization services you, a friend, a family member, your provider or facility must call us to receive admission approval for the proposed service.

Prior Authorization: In-network providers must obtain Prior Authorization in order for you to get benefits for certain services. Prior Authorization criteria will be based on many sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. We may decide that a service that was prescribed or asked for is not medically necessary if you have not first tried other medically necessary and more cost effective treatments.

Anthem HealthKeepers Core DirectAccess, Anthem HealthKeepers Core DirectAccess with Child Dental, Anthem HealthKeepers Core DirectAccess with HSA, Anthem HealthKeepers Essential DirectAccess, Anthem HealthKeepers Preferred DirectAccess, Anthem HealthKeepers Preferred DirectAccess with Child Dental, Anthem HealthKeepers Catastrophic DirectAccess

If you have any questions about the information in this section, you may call the Customer Service phone number on the back of your Member Identification Card.

Types of Requests

- **Precertification** – A required review of a service, treatment or admission for a benefit coverage determination which must be done before the service, treatment or admission start date. For emergency admissions, you, your authorized representative or doctor must tell us within 48 hours of the admission or as soon as possible within a reasonable period of time. For labor / childbirth admissions, precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time.
- **Predetermination** – An optional, voluntary Prospective or Continued Stay Review Request for a benefit coverage determination for a service or treatment. We will check your coverage to find out if there is an exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to decide whether the service meets the definition of medical necessity under this coverage or is experimental/investigative as that term is defined in your coverage.
- **Post Service Clinical Claims Review** – A Retrospective Review for a benefit coverage determination to decide the medical necessity or experimental/investigative nature of a service, treatment or admission that did not need precertification and did not have a predetermination review performed. Medical reviews are done for a service, treatment or admission in which we have a related clinical coverage guideline and are typically initiated by us.

Typically, in-network providers know which services need Precertification and will get any Precertification or ask for a Predetermination when needed. Your primary care physician (PCP) and other in-network providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering provider, facility or attending doctor will get in touch with HealthKeepers to ask for a Precertification or Predetermination review (“requesting provider”). HealthKeepers will work with the requesting provider for the Precertification request. However, you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

Your Rights and Responsibilities

As a member, you have certain rights and responsibilities to help make sure that you get the most from this Plan. It helps you know what you can expect from your overall health care benefit experience and become a smarter health care consumer.

You have the right to:

- Speak freely and privately with your doctors and other health professionals about all health care options and treatment needed for your condition, no matter what the cost or whether it is covered under your Plan.
- Work with your doctors in making choices about your health care.
- Be treated with respect and dignity.

- Privacy of your personal health information, as long as it follows State and Federal laws and our privacy policies.
- Get information about our company and services, and our network of doctors and other health care providers.
- Get more information about your Rights and Responsibilities and give us your thoughts and ideas about them.
- Give us your thoughts and ideas about any of the rules of this Plan and in the way it works.
- Make complaints or appeal about: our organization, any benefit or coverage decisions we make, your coverage, or care received.
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future; and the right to have your doctor tell you how that may affect your health now and in the future.
- Get all of the most up-to-date information about the cause of your illness, your treatment and what may result from that illness or treatment from a doctor or other health care professional. When it seems that you will not be able to understand certain information, that information will be given to someone else that you choose.

You have the responsibility to:

- Treat all doctors, health care professionals and staff with courtesy and respect.
- Keep all scheduled appointments with your health care providers and call their office if you have a delay or need to cancel.
- Read and understand, to the best of your ability, all information about your health benefits or ask for help if you need it.
- To the extent possible, understand your health problems and work with your doctors or other health care professionals to make a treatment plan that you all agree on.
- Give us, your doctors and other health care professionals the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health coverage and insurance benefits you have in addition to your coverage with us.
- Tell your doctors or other health care professionals if you don't understand any care you are getting or what they want you to do as part of your care plan.
- Follow the care plan that you have agreed on with your doctors and other health care professionals.
- Follow all Plan rules and policies.
- Let our Customer Service department know if you have any changes to your name, address or dependents covered under your Plan.
- Pay your monthly premium. Your Evidence of Coverage is issued to the subscriber. The HMO agrees to provide covered services to you under the terms contained in your Evidence of Coverage. The subscriber must pay the applicable premium on or before the last business day of each month preceding the next month's coverage.

Anthem HealthKeepers Core DirectAccess, Anthem HealthKeepers Core DirectAccess with Child Dental, Anthem HealthKeepers Core DirectAccess with HSA, Anthem HealthKeepers Essential DirectAccess, Anthem HealthKeepers Preferred DirectAccess, Anthem HealthKeepers Preferred DirectAccess with Child Dental, Anthem HealthKeepers Catastrophic DirectAccess

Exclusions

This list includes some of the more common services not covered by these plans:

- Acupuncture
- Allergy tests and treatment, except as spelled out in your Evidence of Coverage
- Artificial insemination, fertilization, infertility drugs or sterilization reversal
- Artificial and mechanical hearts
- Alternative or complementary medicine
- Bariatric surgery, unless optional benefit rider has been purchased.
- 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 your 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
- Custodial care
- Dental, except as described in your Evidence of Coverage
- Educational services, except as mandated
- Experimental or investigative treatment
- Non-chemical addictions such as gambling, spending, religious
- Nutritional and dietary supplements
- Over-the-counter drugs, devices or products
- Pharmacy except as spelled out in your Evidence of Coverage
- Routine foot care
- Sclerotherapy (a medical procedure used to eliminate varicose veins and spider veins)
- Services we determine aren't medically necessary
- Sex transformation surgery
- TMJ and Craniomandibular Joint Disorder. Covered services do not include fixed or removable appliance that involve movement or repositioning of the teeth repair of teeth (fillings) or prosthetics (crown, bridges, dentures).
- Vision except as described in your Evidence of Coverage

- Weight loss programs or treatment of obesity except as mandated
- Workers' compensation

Limitations

These services are limited as described below:

- Therapy services
 - Physical/Occupational therapy - 30 combined visits per member per year.
 - Speech therapy - 30 visits per member per year
- Chiropractic - 30 visits for 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

***All plans available with optional bariatric surgery coverage for an additional premium. For more information, contact your HealthKeepers authorized representative.**

Anthem HealthKeepers Core DirectAccess, Anthem HealthKeepers Core DirectAccess with Child Dental, Anthem HealthKeepers Core DirectAccess with HSA, Anthem HealthKeepers Essential DirectAccess, Anthem HealthKeepers Preferred DirectAccess, Anthem HealthKeepers Preferred DirectAccess with Child Dental, Anthem HealthKeepers Catastrophic DirectAccess

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

- Call your HealthKeepers authorized representative.
- Go to anthem.com.

For more information on how to access a Summary of Benefits and Coverage (SBC), please visit www.healthcare.gov and enter SBC in the search field.

The health plans described within this document are not eligible for a premium tax credit subsidy.

This piece is only one part of your information kit. This piece refers to Policy form # VA_HMHS(1/14). Schedule of benefits forms VA_SB_BRZ_3750_ORUT_(1/14), VA_SB_BRZ_4500_ORUR_(1/14), VA_SB_BRZ_5500_ORUM_(1/14), VA_SB_BRZ_6000_ORUP_(1/14), VA_SB_SLV_1500_ORVN_(1/14), VA_SB_SLV_2250_ORVH_(1/14), VA_SB_SLV_2600_ORVC_(1/14), VA_SB_SLV_3350_ORV7_(1/14), VA_SB_GLD_750_ORWD_(1/14), VA_SB_GLD_750_PD_ORWH_(1/14), VA_SB_CAT_6350_ORWM_(1/14) and rider form VA_Bariatric_(1/14).

Selecting health coverage is an important decision.

To assist you, we supply the following for the plans under consideration: Brochure, Benefit Snapshot, Coverage Details and Enrollment Application. If you did not receive one or more of these materials, please contact your HealthKeepers authorized representative to request them.



Virginia Individual Enrollment Application

IMPORTANT: If you are a new applicant, a separate premium payment is required to be submitted with each application. If you are a current Individual policyholder with Anthem Blue Cross and Blue Shield or HealthKeepers, Inc., premium payment is required before the requested effective date. Please complete the Payment Method for Individual Applications Form and send it with your completed enrollment application. If premium is not provided as described above we will not process your application. If you have questions while completing this application, please contact your insurance agent/broker directly. If you have not worked with an insurance agent/broker, please call 1 (877) 212-1793. If you have questions about a previously submitted application, please call 1 (855) 330-1108.

Please complete in blue or black ink only.

Section A – Coverage Information

Application Type (select one):

- New Coverage Change policy coverage Add dependent(s) to current coverage
- Policy No. _____ Policy No. _____

Open Enrollment

During the annual Open Enrollment period, you may apply for coverage, or members can change plans. The earliest Effective Date for the Initial Open Enrollment is January 1, 2014. For applications received after December 15, 2013, the Effective Date for the initial Open Enrollment period is the first day of the following month if receipt of application and premium is between the 1st and 15th of the month. If receipt of application and premium is after the 15th of the month, your Effective Date will be the first day of the month following plus one additional month (example: application with premium receipt is January 20th, your effective date is March 1st).

Applications must be received during the Open Enrollment period. Outside the Open Enrollment period referenced above, the applicant may still enroll if he/she has a qualifying event as defined below. Notice of a qualifying event must be received by HealthKeepers, Inc. within 60 days of the qualifying event.

Qualifying Events

Please check the qualifying event:

- Involuntary loss of Minimum Essential Coverage for any reason other than fraud, intentional misrepresentation of a material fact or failure to pay premium;
- Loss of Minimum Essential Coverage due to dissolution of marriage/domestic partnership;
- Marriage/Domestic Partnership;
- Adoption or placement for adoption or appointment of guardianship;
- Birth.

Please provide the date of the qualifying event: _____

If you are applying due to a qualifying event and your application is approved, your effective date is as follows:

- In the case of birth, adoption or placement for adoption or appointment of guardianship, coverage is effective on the date of birth, adoption, or placement for adoption or appointment of guardianship; or
- In the case of marriage, or loss of Minimum Essential Coverage, coverage is effective on the first day of the month following receipt of your application.

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Section B – Applicant Information

Last Name		First Name		MI	Social Security Number*
Home Address (street and P.O. Box if applicable)					
City		State	ZIP	County	
Billing Address (street and P.O. Box if different from above)					
City		State	ZIP		
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /		
Primary Phone Number ()	Secondary Phone Number ()		E-mail*		

**This information is used for internal purposes only and will not be disclosed unless you select the health savings account option in this Application.*

Section C – Spouse or Domestic Partner to be Covered Information

Last Name		First Name		MI	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner
Social Security Number*		Sex <input type="checkbox"/> M <input type="checkbox"/> F		Date of Birth / /	

**This information is used for internal purposes only and will not be disclosed unless you select the health savings account option in this Application.*

Section D – Child Dependents to be Covered Information (All fields required. Attach a separate sheet if necessary).

Dependent information must be completed for all child dependents (if any) to be covered under this coverage. An eligible dependent may be your children, or children of your spouse, including newborn children, stepchildren, legally adopted children, and legal guardianships (to the end of the calendar month in which they turn age 26). A subscriber has the option to cancel dependent coverage effective on the next available date after notice is received by HealthKeepers, Inc. Eligibility will be continued past the age limit only for those already enrolled Dependents who cannot work to support themselves by reason of intellectual or physical disability. These Dependents must be allowed as a federal tax exemption by the subscriber or subscriber’s spouse. (List all dependents beginning with the eldest).

Last Name	First Name	MI	Sex	Date of Birth mm/dd/yyyy	Social Security Number*	Relationship to Applicant
			M F <input type="checkbox"/> <input type="checkbox"/>	/ /		<input type="checkbox"/> Child <input type="checkbox"/> Other: _____
			M F <input type="checkbox"/> <input type="checkbox"/>	/ /		<input type="checkbox"/> Child <input type="checkbox"/> Other: _____
			M F <input type="checkbox"/> <input type="checkbox"/>	/ /		<input type="checkbox"/> Child <input type="checkbox"/> Other: _____
			M F <input type="checkbox"/> <input type="checkbox"/>	/ /		<input type="checkbox"/> Child <input type="checkbox"/> Other: _____
			M F <input type="checkbox"/> <input type="checkbox"/>	/ /		<input type="checkbox"/> Child <input type="checkbox"/> Other: _____

*This information is used for internal purposes only and will not be disclosed unless you select the health savings account option in this Application.

Are all applicants listed on this application legal residents of the United States and residents of the state in which you are applying for coverage? Yes No

If NO, who? _____

Are all applicants listed on this application United States citizens, nationals or lawfully present non-citizens? Yes No

If NO, who? _____

Has any applicant used tobacco products 4 or more times per week, on average, in the last 6 months? Yes No

If YES, who? _____

Preferred written language? (Optional)

Preferred spoken language? (Optional)

English (ENG)

Spanish (SPN)

English (ENG)

Spanish (SPN)

Section E – Medical Coverage

Plan Name and Deductible/Coinsurance Options

Select ONE Plan...then select ONE Individual Deductible/Coinsurance option.

Total Family Deductible is two (2) times the amount shown.

Anthem HealthKeepers Core DirectAccess

\$4,500/35% cabw-(0RUR)

\$5,500/25% caam-(0RUM)

Anthem HealthKeepers Core DirectAccess with Bariatric Surgery

\$4,500/35% cacb-(0RUZ)

\$5,500/25% caab-(0RUV)

Anthem HealthKeepers Core DirectAccess with Child Dental

\$4,500/35% cdbw-(0RV3)

Anthem HealthKeepers Core DirectAccess with Child Dental and Bariatric Surgery

\$4,500/35% cdab-(0RV5)

Anthem HealthKeepers Essential DirectAccess

\$1,500/30% cbky-(0RVN)

\$2,250/20% cbjs-(0RVH)

\$2,600/20% cbfs-(0RVC)

\$3,350/15% cbau-(0RV7)

Anthem HealthKeepers Essential DirectAccess with Bariatric Surgery

\$1,500/30% cbmb-(0RW8)

\$2,250/20% cbib-(0RW3)

\$2,600/20% cbeb-(0RVY)

\$3,350/15% cbab-(0RVT)

Anthem HealthKeepers Preferred DirectAccess

\$750/20% ccam-(0RWD)

Anthem HealthKeepers Preferred DirectAccess with Bariatric Surgery

\$750/20% ccab-(0RWF)

Anthem HealthKeepers Preferred DirectAccess with Child Dental

\$750/20% cdda-(0RWH)

Anthem HealthKeepers Preferred DirectAccess with Child Dental and Bariatric Surgery

\$750/20% cdeb-(0RWK)

Anthem HealthKeepers Catastrophic DirectAccess (only available for Applicants under age 30 or otherwise qualified)

\$6,350/0% cmaa -(0RWM)

Anthem HealthKeepers Catastrophic DirectAccess with Bariatric Surgery only available for Applicants under age 30 or otherwise qualified)

\$6,350/0% cmab -(0RWP)

HSA Plans

Anthem HealthKeepers Core DirectAccess with HSA

\$3,750/25% cacd-(0RUT)

\$6,000/15% caas-(0RUP)

Anthem HealthKeepers Core DirectAccess with HSA and Bariatric Surgery

\$3,750/25% cadb-(0RV1)

\$6,000/15% cabb-(0RUX)

YES, I would like to establish a health savings account in conjunction with the HSA-compatible health plan I selected. Please forward my information to HealthKeepers, Inc.'s banking partner. (Please fill in your social security number in Section B.)

NO, I DO NOT want to establish a health savings account in conjunction with the HSA-compatible health plan I selected above. Please **DO NOT** forward my information to HealthKeepers, Inc.'s banking partner.

Section F – Dental Coverage

Yes, I wish to add dental coverage (at an extra cost per individual)

Select ONE plan below:

Anthem Dental Pediatric
 Anthem Dental Pediatric Enhanced

Anthem Dental Adult
 Anthem Dental Adult Enhanced

Anthem Dental Family
 Anthem Dental Family Enhanced

Select who you are enrolling (applies to individuals listed on this application only):

Applicant only

Applicant & Spouse or Domestic Partner only

Applicant & all dependent children listed

Applicant, Spouse or Domestic Partner, and all dependent children listed

All dependent children listed

Important: You must enroll in pediatric dental coverage unless you will be enrolled in a standalone dental plan that has been certified by a state Exchange. To determine if your standalone dental plan has been certified by a state Exchange, please refer to your health plan enrollment information or the website for your state Exchange.

Please check if you will be enrolled in a standalone dental plan meeting this requirement.

Section [G] – Other Health Coverage

Are you or anyone applying for coverage currently eligible for Medicare?

Yes No

If **YES**, who? _____

Are you or anyone applying for coverage currently receiving Social Security Disability, Medicare, Medicaid or other government program benefits, or unable to work due to disability or receiving Workers' Compensation benefits?

Yes No

If **YES**, who and reason:

Start date of benefits/coverage: ____/____/____ End date of benefits/coverage: ____/____/____

Do you, or anyone applying for coverage, currently have health care coverage?

Yes No

If YES, please provide the following:

Name(s) of covered persons. If the whole family, simply write ALL in space below.		Identification Number(s)
Name and phone number of prior carrier(s)		
Type of coverage <input type="checkbox"/> Group <input type="checkbox"/> Individual	Effective Date of Coverage	

Will you be cancelling this coverage if approved for HealthKeepers, Inc. coverage?

Yes No

If **YES**, what is the cancellation date? _____

Section H – Significant Terms, Conditions and Authorizations (TERMS)

Please read this section carefully before signing the application.

- I understand that although HealthKeepers, Inc. requires payment with my application, sending my initial premium with this application, and the receipt of my payment by HealthKeepers, Inc., does not mean that coverage has been approved. I may not assign any payment under my HealthKeepers, Inc. program. I am applying for the coverage selected on this application. I understand that, to the extent permitted by law, HealthKeepers, Inc. reserves the right to accept or decline this application, and that no right whatsoever is created by this application. I understand that if my application is denied, my bank account or credit card will not be charged.
- I am responsible to timely notify HealthKeepers, Inc. of any change that would make me or any dependent ineligible for coverage.
- I understand HealthKeepers, Inc. may convert my payment by check to an electronic Automated Clearinghouse (ACH) debit transaction and that my original check will be destroyed. The debit transaction will appear on my bank statement although my check will not be presented to my financial institution or returned to me. This ACH debit transaction will not enroll me in any HealthKeepers, Inc. automatic debit process and will only occur each time I send a check to HealthKeepers, Inc. Any resubmissions due to insufficient funds may also occur electronically. I understand that all checking transactions will remain secure, and my payment by check constitutes acceptance of these terms.
- By signing this application, I agree and consent to the recording and/or monitoring of any telephone conversation between HealthKeepers, Inc. and myself.
- I understand I am applying for individual health coverage which is not part of any employer-sponsored plan. I certify that neither I nor any dependent is receiving any form of reimbursement or compensation for this coverage from any employer. I understand that I am responsible for 100% of the premium payment and I am also responsible to ensure that premiums are paid.
- I understand that my domestic partner, if applicable, is only eligible for coverage if: he or she has been my sole domestic partner for 12 months or more; he or she is at least 18 years of age; he or she is mentally competent; he or she is not related to me in any way (including by blood or adoption) that would prohibit us from being married under state law; he or she is not married to or separated from anyone else; and he or she is financially interdependent with me.
- By checking this box, I authorize and expressly consent that HealthKeepers, Inc. and its affiliated companies may send e-mail communications instead of sending communications by mail, including but not limited to legally required Plan Notices and underwriting, enrollment and billing and explanation of benefits statements, to the e-mail address I have provided on this Application. I understand that I can revoke this authorization or request paper copies at any time free of charge by contacting HealthKeepers, Inc. customer service or online at www.anthem.com.
- I acknowledge that I have read the Significant Terms, Conditions, and Authorizations, and I accept such provisions as a condition of coverage. I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and belief, and I understand they are being relied on by HealthKeepers, Inc. in accepting this application. Any act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact found in this application may result in denial of benefits, rescission or cancellation of my coverage(s).

I give this authorization for and on behalf of any eligible dependents and myself if covered by HealthKeepers, Inc.. I am acting as their agent and representative.

This application shall be altered solely by the applicant or with his or her written consent.

SIGN HERE	Signature of Applicant* or Legal Representative X	Date
	Signature of Spouse or Domestic Partner or Dependent Child(ren) age 18 or over (if to be covered) or Legal Representative X	Date
	Signature of Dependent Child(ren) age 18 or over (if to be covered) X	Date

** (or Custodial Parent's or Guardian's signature if applicant is under age 18)*

Section I – Agent/Broker Certification

To be completed by your HealthKeepers, Inc.-appointed agent/broker:

Did you see the proposed subscriber and spouse/domestic partner, if applying at the time this application was executed? Yes No

If **NO**, please explain: _____

I certify to the best of my knowledge and belief, the responses herein are accurate.

Agent/Broker Signature X		Date	
Agent/Broker Name (please print)		Agent/Broker Street Address/Suite No./Personal Mail Box (PMB) No.	
Agent/Broker ID/TIN	Agency ID/Parent TIN	City	State ZIP
Agent/Broker Phone No.	Agent/Broker Fax No.	Agent/Broker E-mail	
GA (if applicable)		GA code (if applicable)	

Authorization for Use of Protected Health Information

By signing below: I authorize HealthKeepers, Inc., or an agent/broker, subsidiary or affiliate that has a business associate contract with HealthKeepers, Inc., to obtain any medical records or other health history information concerning me and any family member listed on my Application from any physicians, hospitals, pharmacies, other health care providers, pharmacy benefits managers, health benefits plans, health insurers, medical or pharmacy benefit administrators, Consumer Reporting Agencies, MIB, Inc., formerly Medical Information Bureau (MIB), and/or insurance support organizations for the purpose of collecting information in connection with administration of benefits.

This authorization is subject to revocation at any time by written notice to HealthKeepers, Inc. except to the extent that HealthKeepers, Inc. has already taken action in reliance on this authorization. If I revoke this authorization after I initially apply for coverage, I understand that I/we will not be considered for coverage. If I revoke this authorization after I ask to upgrade my coverage or add a family member, I understand that the change will not be made. I understand that if my and/or my family's information is to be received by individuals or organizations that are not health care providers, health care clearinghouses or health plans governed by federal privacy regulations, my/our information might be re-disclosed by any of those recipients and will not be protected by federal privacy regulations. A copy of this authorization is available to me, or to my authorized representative, upon request and will serve as the original.

Unless previously revoked, this authorization is valid for 24 months from the date of signature.

S I G N H E R E	Printed name of Applicant/Member X	Signature of Applicant/Member or his/her Legal Representative X	Date
	Printed name of Spouse or Domestic Partner or Dependent Child* age 18 or over listed on Application X	Signature of Spouse or Domestic Partner or Dependent Child* or his/her Legal Representative X	Date
	Printed name of Dependent Child* age 18 or over listed on Application X	Signature of Dependent Child* or his/her Legal Representative X	Date

**If listed on your application or change form, your spouse/domestic partner and each dependent child age 18 or over must sign above. If a legal representative signs on behalf of the applicant or spouse or domestic partner, a copy of the legal representative's authority must be attached to the application.
A photocopy of this form will be as valid as the original. You or an authorized representative have the right to receive a copy of this Authorization upon request.*



Anthem HealthKeepers
Offered by HealthKeepers, Inc.

Please mail this application to the following address:

Anthem Blue Cross and Blue Shield
P.O. Box 9041
Oxnard, CA 93031-9041

Or

Fax to: 1 (800) 848-2512

HealthKeepers, Inc. is an independent licensee of the Blue Cross and Blue Shield Association. ©ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Payment Methods for Individual Applications – Virginia



Applicant / Member Name:	Primary Applicant's SSN:
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Premium Payment is required. Please choose from Option 1 or 2
Please Note: All Payments will be debited as soon as the date of enrollment.

<input type="checkbox"/> OPTION 1 – If you choose the following option for INITIAL and FUTURE MONTHLY payments, you are NOT required to make a selection from Option 2 for your initial payment. <input type="checkbox"/> Monthly Automatic Premium Payment (complete Section A)	<input type="checkbox"/> OPTION 2 – If you did not select OPTION 1 , please choose from the options below for your INITIAL premium payment. If you choose one of these options, you will receive a bill every month thereafter for which you are responsible for payment. <input type="checkbox"/> Paper Check* <input type="checkbox"/> Electronic Check (complete Section B) <input type="checkbox"/> Credit / Debit Card (complete Section C)
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A. Monthly Automatic Premium Payment – By providing your bank information, you authorize us to electronically debit your bank account. I understand this authorization will apply to all products selected. Subsequent premium amounts will be debited on the day you request below:

Checking Account
 Savings Account
 (You may need to contact your financial institution for routing and account number information.)

Requested Debit Day: ____ (1st to 6th of each month).
 If no date is requested, your premiums will be debited on the first of each month.

9-Digit Bank Routing Number

Bank Account Number

As a convenience to me, I request and authorize you to pay and charge to my account checks drawn on that account by and payable to the order of Anthem Blue Cross and Blue Shield, provided there are sufficient collected funds in said account to pay the same upon presentation. I understand that the initial payment amount may vary as a result of change(s) during eligibility review, and/or subsequent payment amount may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents, moving my residence, changing coverage and/or changes made by Anthem which you are notified pursuant to your plan/policy. I agree that your rights in respect to each such debit shall be the same as if it were a check signed personally by me. I authorize Anthem Blue Cross and Blue Shield to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Anthem Blue Cross and Blue Shield premiums. This authority is to remain in effect until revoked by me by providing you a 30-day written notice. I agree that you shall be fully protected in honoring any such debit. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance. **NOTE:** Should your withdrawal not be honored by your bank, you will automatically be removed from Monthly Automatic Premium Payment and will be billed by mail. **You will incur a service charge for any withdrawal not honored.**

Authorized Signature (as it appears in the financial institution's records)	Account Holder Name (Please PRINT)	Date
X		

B. Electronic Check – In lieu of sending a Paper Check, we can submit this same information electronically. We will need you to complete the information below. We require an exact amount to be debited.

Account Holder Name (Please PRINT)	Bank Routing Number	Account Number	Amount
			\$

C. Credit / Debit Card - As a convenience to me, I request and authorize Anthem Blue Cross and Blue Shield to charge my card for a one time initial debit upon approval. I understand this authorization will apply to all products selected. I understand that the initial payment amount may vary as a result of change(s) during eligibility review and/or subsequent payment amounts may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents, moving my residence changing coverage, and/or changes made by Anthem Blue Cross and Blue Shield which you are notified pursuant to your plan/policy. I agree that you shall be fully protected in honoring any such card payments. I further agree that if any such card payment be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever, including any fees imposed by my bank, should my card be rejected even though such dishonor results in forfeiture of coverage. **We accept Visa and MasterCard.**

Card Number:

Expiration Date:

Billing address for this Credit / Debit Card:

City:

Zip Code:

Authorized Signature (as it appears on the credit card)	Cardholder Name (as it appears on the credit card – Please Print)	Date
X		

* When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use this information from your check to make an electronic fund transfer, funds will be withdrawn from your account as soon as the day of approval and you will not receive your check back from your financial institution.

How to enroll

Sign up today for our off-exchange dental and vision plans!

For Dental Prime plans:

Fill out a form online or by hand.

- Go to AnthemDentalAdmin.com.
- Or fill out and sign the appropriate form. Then give the form to your agent or mail it to us at:
Dental Enrollment Department
P.O. Box 1193
Minneapolis, MN 55440-1193

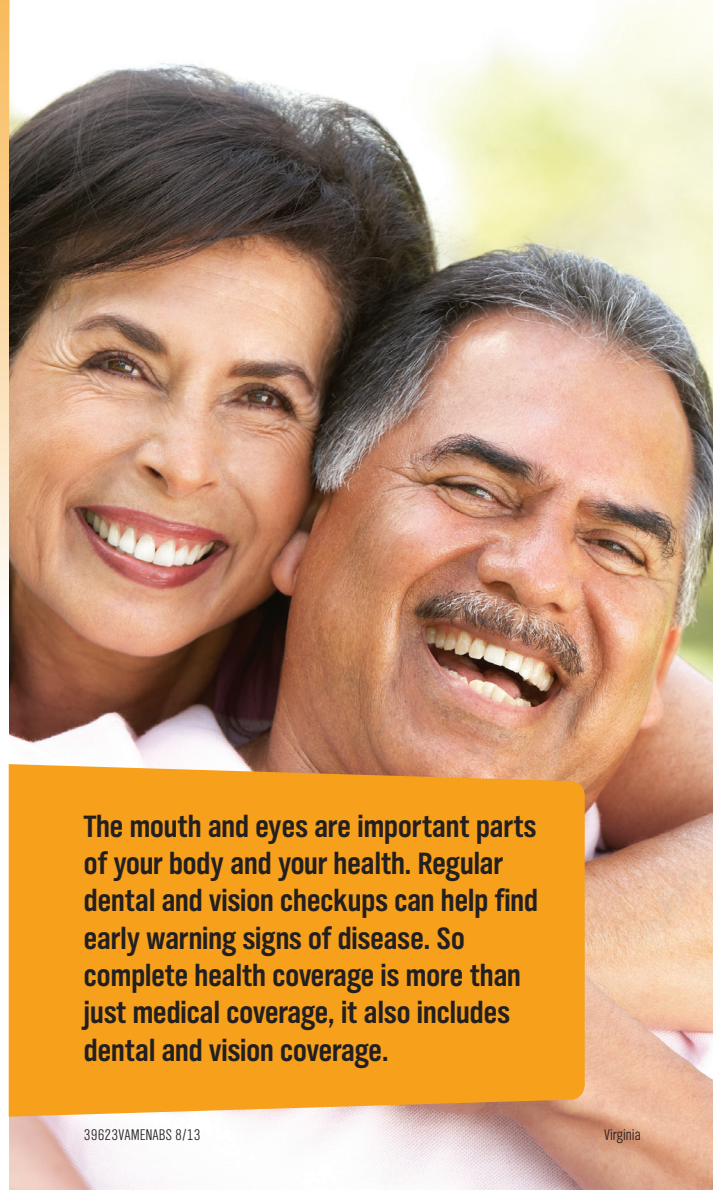
For Anthem Dental Adult and Dental Family plans:

Fill out and sign the form. Give your completed form to your agent or mail it to us at:

Dental Enrollment Department
P.O. Box 9041
Oxnard, CA 93031-9041



Dental and vision coverage for your whole health



The mouth and eyes are important parts of your body and your health. Regular dental and vision checkups can help find early warning signs of disease. So complete health coverage is more than just medical coverage, it also includes dental and vision coverage.

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Virginia

Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. Independent licensee of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Health care reform

Essential health benefits include dental and vision

You've probably heard about the Affordable Care Act (ACA), also known as health care reform. Starting on January 1, 2014, many health plans will be required to cover 10 essential health benefits, including one for dental and vision for children.

Pediatric dental is one of 10 essential health benefits that individuals are responsible for purchasing in the off-exchange marketplace.

To comply with the ACA, consumers have the following purchase options:

- A medical plan that has pediatric dental essential health benefits coverage, **or**
- A standalone pediatric dental essential health benefits policy, **or**
- A standalone adult or family dental plan that includes pediatric dental essential health benefits coverage.

On exchange

This means buying your coverage through the exchange, also known as the Health Insurance Marketplace, which is run by the state or federal government.

If you're eligible for a subsidy to help pay for your health coverage and want to use it, you must get your medical plan through the exchange.

To learn more, visit your state's exchange website at www.healthcare.gov.

Off exchange

If you aren't eligible for a subsidy, or if you're shopping for a dental or vision plan, you don't have to buy through the exchange. **You can still get coverage as before, through a broker or agent, or directly from an insurance company.**

Because there are rules for plans on the exchange, you might find that plans off the exchange offer more choices.

Our off-exchange products

Anthem Blue Cross and Blue Shield (Anthem) can help you get the dental and vision care you need — which can help you get a better handle on your total health. That's why many of our dental plans include exams, cleanings and X-rays covered 100%, and all of our vision plans include coverage for yearly vision exams.

Anthem dental plans

We offer a variety of individual and family dental plan options to fit your needs and budget. These plans include:

- Dental Prime for Individuals and Families
- Anthem Dental Adult and Anthem Dental Family plans

The table helps you compare your plan choices. So you have many ways to get the smile you want, and keep a healthy mouth.

Anthem vision plans

Optional Blue View VisionSM plan available

You can add optional Blue View Vision benefits to your Dental Prime plan. This plan features:

- **A broad, convenient group of national providers** — Blue View Vision providers include more than 30,000 private practice doctors and more than 25,000 locations. This includes the nation's leading retail stores like LensCrafters®, Sears OpticalSM, Target Optical®, JCPenney® Optical, and most Pearle Vision® locations. These stores offer evening and weekend hours. You can also use your benefits at 1-800-CONTACTS®.
- **A complete picture of your health between your eye care and health care providers** — With Blue View Vision, network eye care providers can see and share data about a patient's eye health — including diagnoses, lab results and prescriptions — with other network providers. So any network provider can better understand your whole health.
- **“Add-ons” at no extra charge** — Factory scratch coating on eyeglass lenses is included at no extra cost. Transitions® and polycarbonate lenses for kids younger than 19 can be added at no extra cost.
- **Plus more benefits** to help you save money on your eye care.

In-network Dental Benefits

	Dental Prime plans			Anthem Dental plans	
	Plan A	Plan B	Plan C	Adult*	Adult Enhanced*
Diagnostic & preventive (D&P) – (cleaning, exams, X-rays) no waiting period	100%	100%	100%	100%	100%
Extra cleaning	For those who are pregnant or living with diabetes			Not covered	
Basic services – (fillings) 6-month waiting period	Not covered	80%	80%	50%	80%
Brush biopsy	Not covered	80%	80%	Not covered	
Complex and major services – 12-month waiting period	Not covered	50%	50%	30%	50%
Endodontic/periodontic/oral surgery (root canal, scaling, tooth removal)					
Prosthetic services (crowns, dentures, bridges)	Not covered	Not covered	50%	30%	50%
Orthodontics	Not covered			Not covered	
Dental implants	Not covered	Not covered	50%	30%	50%
International Emergency Dental Program	Included			Included	
Providers	Dental Prime			Dental Prime	
Deductible per person	None	\$50	\$50	\$50	\$50
Yearly limit per person	\$500	\$1,000	\$1,250	\$750	\$1,000
Yearly out-of-pocket limit	None			None	
Premium payment options	Credit, debit/ATM card options			No credit, debit/ATM card options	
Premium discount	5% discount when paying each year			No discount	

*Anthem Dental Adult benefits differ from Dental Pediatric benefits. Ask your Anthem representative for more details.

This is only a brief description of some plan benefits. Please refer to the Certificate of Coverage for more complete details including benefits, limitations and exclusions.

Note: plan availability, rates and terms subject to regulatory review and approval. At the time of this brochure's creation, the products and plans described were pending regulatory review and approval. In the event of any conflict between this brochure and the final plans and terms ultimately approved by the regulator, the plans and terms approved by the regulator shall control.

The International Emergency Dental Program is managed by DeCare Dental. DeCare Dental is an independent company offering dental management services to Anthem Blue Cross and Blue Shield.

Individual dental and vision premiums for Virginia



For policies with start dates beginning January 2014

We know that you have choices when it comes to health care coverage. Anthem Blue Cross and Blue Shield (Anthem) gives you access to complete dental coverage and one of the largest dental networks in the state. But cost is important to you too.

Because insurance can be a big part of your budget, we make every effort to keep our costs low – so you pay less for coverage. The price you pay for your dental premium depends on several things, including how much dental care costs and where you live.

How much will I pay each month for dental coverage?

Premiums are often set by rating areas. In such a case, to find your monthly cost, look for your rating area based on the ZIP code or county of where you live. Then look at the rate charts. Different plans will have different rating areas and rate tables.

Anthem Dental Adult and Family plans

To find your cost for these plans, find your rate area and then select the table for the plan chosen for the adult member. With Anthem Dental Family plans, you will not be charged premiums for more than three children, even if the family has more children covered by the plan.

Rate area 1: ZIP codes starting with 227-246; Rate area 2: all other ZIP codes

Anthem Dental Adult

	Area	
	1	2
1 Adult	\$34.77	\$32.65
2 Adults	\$69.54	\$65.30

Family

Anthem Dental Pediatric

	Area 1	Area 2
1 Adult + 1 pediatric	\$57.40	\$53.51
1 Adult + 2 pediatric	\$80.90	\$75.18
1 Adult + 3 pediatric	\$104.40	\$96.85
2 Adults + 1 pediatric	\$91.30	\$85.35
2 Adults + 2 pediatric	\$114.80	\$107.02
2 Adults + 3 pediatric	\$138.30	\$128.69

Anthem Dental Adult Enhanced

	Area	
	1	2
1 Adult	\$39.45	\$37.04
2 Adults	\$78.90	\$74.08

Family

Anthem Dental Pediatric Enhanced

	Area 1	Area 2
1 Adult + 1 pediatric	\$73.55	\$69.14
1 Adult + 2 pediatric	\$104.04	\$97.57
1 Adult + 3 pediatric	\$134.53	\$126.00
2 Adults + 1 pediatric	\$116.61	\$109.85
2 Adults + 2 pediatric	\$147.10	\$138.28
2 Adults + 3 pediatric	\$177.59	\$166.71

Dental Prime plans

Premiums (Annual rates reflect a 5% discount when pre-paying annually)	Plan A		Plan B		Plan C	
	Monthly	Annual	Monthly	Annual	Monthly	Annual
ZIP codes starting with 227-246						
Individual	\$25.05	\$285.55	\$42.35	\$482.80	\$53.30	\$607.60
Individual + 1	\$48.75	\$555.75	\$82.35	\$938.80	\$103.65	\$1,181.60
Family	\$78.00	\$889.20	\$131.70	\$1,501.40	\$165.85	\$1,890.70
All other ZIP codes						
Individual	\$20.20	\$230.30	\$34.15	\$389.30	\$42.95	\$489.65
Individual + 1	\$39.30	\$448.00	\$66.35	\$756.40	\$83.55	\$952.45
Family	\$62.90	\$717.05	\$106.20	\$1,210.70	\$133.70	\$1,524.20

Blue View Vision plans

This vision option is available only when combined with Dental Prime for Individuals and Families

Premiums (Annual rates reflect a 5% discount when pre-paying annually)	Monthly	Annual
Individual	\$8.29	\$94.55
Individual + 1	\$14.51	\$165.47
Family	\$23.22	\$264.74

Rates apply to members under age 65 and are subject to change.

As of January 1, 2014, the Affordable Care Act (ACA) or health care reform law, requires health insurers to pay an annual fee to fund premium subsidies and Medicaid expansion. This fee applies to fully insured dental plans. The monthly premiums listed above include the ACA insurer fee.
 Note: plan availability, rates and terms subject to regulatory review and approval. At the time of this brochure's creation, the products and plans described were pending regulatory review and approval. In the event of any conflict between this brochure and the final plans and terms ultimately approved by the regulator, the plans and terms approved by the regulator shall control.

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