2017 Plan Year: Virginia Individual and Family

Your Health Plan Guide

Bronze, Silver, Gold and Catastrophic plans

Anthem BlueCross BlueShield

And Its Affiliate HealthKeepers, Inc.

Looking for a new health plan?

We can help.

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Why HealthKeepers?

Health plans don’t have to be complicated.

We understand that every individual and family is unique. That’s why we offer many 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 with access to major hospital systems.
- Dedicated customer service.
- All your benefits, including dental and vision, from one source.
- Competitive pricing.
- Convenient online tools, including 24/7 access to doctors through LiveHealth Online.
- A simple enrollment process.
- Coordinated care that connects your doctors and other health care providers.
- Resources to support your health care goals.

HealthKeepers is right there with you.

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

- Local presence where you live and work
- A brand you can trust.

You want the best value your health care dollars can buy. And in Virginia, that's our goal — through our networks and our experience.

* Based on Internal Data, 2016.

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What we cover

All our plan options have one major goal — to help you stay healthy and provide 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 plenty in between!

Built in 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 (going to the emergency room, also known as the ER) or urgent care center, when medically necessary
- Hospitalization and inpatient services (such as surgery)
- Laboratory and radiology services (includes blood work, screenings and X-rays)
- Mental health and substance use disorder services (includes counseling and psychotherapy)
- Pediatric dental and vision coverage for children up to age 19†

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

With HealthKeepers, you pay no copay, no coinsurance and no deductible for covered **in-network** preventive services. So you can stay on top of your health care and your finances!*

- Pregnancy, maternity and newborn care (care before, during and after pregnancy)
- Prescriptions
- Rehabilitative and habilitative services and devices (hospital beds, crutches, oxygen tanks)
- Visits to doctors in your plan for preventive care services* (wellness exams, shots, screenings) and chronic disease management

* Nationally recommended preventive care services from in-network providers have no copay, no coinsurance 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.

† 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.

Pharmacy

Getting the most out of your pharmacy benefits can help keep you healthy and save you money. Here's what you need to know:

About our covered drug list

HealthKeepers' pharmacy plans have a formulary/drug list, which is a list of covered prescription drugs that includes hundreds of brand name and generic medicines. Our individual and family plans use the Select Drug List, which offers drugs in every category and class that meet or exceed ACA requirements. The list tells you what tier your drug is in and provides guidance on how your cost shares are affected. Cost shares usually go up the higher the drug tier. Talk to your doctor about possible lower-cost options if your drug is in a higher tier.

Access all of your pharmacy information at anthem.com

- Find out if your medication is covered. Check out our Select Drug List at **anthem.com/pharmacyinformation** and click on the link, **Virginia Select Drug List (Searchable)**.
- See if your preferred pharmacy is in the plan's network. Visit **anthem.com/pharmacyinformation** and select the **Rx Networks** tab.
- Learn more about using your pharmacy benefits, your drug list and get answers to questions about prior authorization and step therapy. See our list of FAQs located on the **Customer Support** tab.

Together with medical – better and easier than ever

With our combined pharmacy and medical programs, your doctor has a better picture of your health which can help result in:

- Better overall health
- A simplified experience
- Fewer hospital stays and reduced medical costs*
- Improved medication compliance
- Increased cost savings for prescriptions*

Save with prescription drug benefits

HealthKeepers wants to help lower the cost of your prescription drugs, improve your overall health and deliver top-notch customer service. Here's how:

Save with Home Delivery Choice

We offer home delivery of your medicines right to your door. With the Home Delivery Choice program, you must choose how you want to get the medicines you take for ongoing conditions like indigestion, high blood pressure, high cholesterol or diabetes — at your local pharmacy or delivered to your doorstep.

We'll contact you by phone and mail to tell you about the program and its benefits. You can use a retail pharmacy for two fills, but after the second fill, your medicines will no longer be covered at your pharmacy until you make a final decision.

Using home delivery may help you save money. And it makes it easy for you to get your medicine quickly and safely.

Members can access HealthKeepers' online pharmacy tools – anytime, anywhere

Manage everything you want and need to know about your prescription benefits in one place. It's easy. It's convenient. From getting your prescriptions filled to receiving health alert notifications and more, you can find it all by using our prescription benefit tools on **anthem.com**. And many of the same helpful tools are available on your mobile device, so you can manage your drug benefit wherever you are.

* Outcomes based on 2014 integrated analysis. Results do not represent a guarantee of outcomes, group-specific results and cost savings will vary.

How to choose a plan

Networks...why choosing a doctor in your plan matters

One thing to think about when shopping for a health plan is your health plan's network of participating providers.

When Anthem and HealthKeepers set up medical, dental and vision networks, we negotiate with doctors, hospitals and labs on the cost of services. For example, a doctor may normally charge $150 for an X-ray for a patient without medical benefits. We may negotiate with that same doctor to discount the rate for our members down to $100. Once this agreement is made, the doctor becomes part of our network of health care providers.

Bottom line: If you have a favorite doctor, hospital or other health care provider, you should always check to see if that provider is in our network, so you can get the benefit of the discounted or in-network rate.

Providers in your plan may include:

- 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)

Our Find a Doctor tool — it's quick and easy

Go to **anthem.com/findadoctor** and search using the plan/network (**Pathway Tiered Hospital**) you're considering.

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 Anywhere** mobile app to your mobile device.

Types of plans: POS and HMO

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.

- **Health maintenance organization (HMO):** HMO plans don't offer out-of-network benefits, except for emergency and urgent care or when a service is preapproved. If you go outside the network for any other reason, you'll have to pay 100% out of pocket.
- **Point of service (POS):** With our POS plans, you can go out of network, but you'll pay a higher deductible, copay or coinsurance and out-of-pocket limit. Plans with out-of-network benefits have "POS" in the plan name. POS plans are available in all regions within our service area. Our service area includes all of Virginia except for the City of Fairfax, the Town of Vienna and the area east of State Route 123.
- **Tiered hospitals and facilities:** Our network includes tiered hospitals and facilities. Hospitals and facilities are split into two categories: Tier 1 and Tier 2. You pay a lower cost share for hospitals and facilities in Tier 1. To see what tier a hospital or facility is in, visit the Find a Doctor tool at anthem.com/findadoctor.

Travel coverage

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 you don't have to! With the Blue Cross and Blue Shield Association's BlueCard® program, you can access emergency or urgent care through BlueCard's Traditional PAR network no matter where you are in the United States (U.S.). You can access any provider for emergency or urgent care, but you'll pay less out of pocket when you use BlueCard providers.

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 and urgent care outside our service area, but you'll pay less out of pocket when you use participating BlueCard providers through the Traditional PAR network.

The difference between doctors in the plan and doctors outside the plan

Doctors in the plan: Doctors and other health care providers who contract with us to provide care at discounted rates.

Doctors outside the plan: Doctors and other health care providers who are not contracted with the health plan.

If you choose to go to a doctor not in your plan, you'll pay more out of pocket.

What do you need?

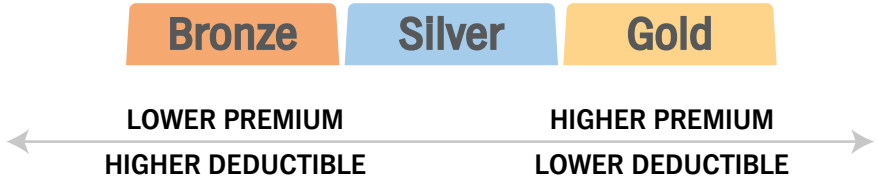
Choosing the right health care plan can be challenging. To help you decide, consider the questions below. And remember, your HealthKeepers sales representative can provide answers and give advice.

What matters most to you?

- **Does the plan meet your coverage needs?** How often do you see doctors and specialists? What prescription medications do you take regularly? Are you planning any procedures this year?
- **Do you have a certain doctor you like to see?** If you answered yes, then you can use our Find a Doctor tool at **anthem.com/findadoctor** to check if your doctor is in the plan you're considering.
- **Do you need to know if your medication is covered?** Check out our drug list at **anthem.com/pharmacyinformation** and click on the link, **Virginia Select Drug List (Searchable)**.
- **Is a Catastrophic plan an option?** If you're under age 30 or are 30 or older with an approved hardship exemption from the Health Insurance Marketplace you may qualify for a high deductible, low monthly payment, Catastrophic plan. Catastrophic plans can help protect you from worst-case scenarios like serious accidents or illnesses.

Plan choices

Metal Levels



Health savings account (HSA)

If you like the idea of lowering your health care costs and your taxes, a health savings account (HSA) could be a good option for you.

- **What is it?**
  It's a savings account you can open when you have a qualified high-deductible health plan (HDHP). You set up the HSA through a bank and fund it with your post tax dollars.
- **Why choose it?**
  It can help you pay for health care expenses, including prescriptions. Plus, you can claim your HSA contributions as tax deductions, earn interest on your money and roll over the year-end balance.
- **How can you learn more?**
  Check with your tax advisor to see if an HSA plan is right for you. Plans with 'HSA' in the name are HDHPs and are compatible with an HSA. For more information on HSAs, review our HSA flier included with this brochure.

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 covered services you receive with your health insurance company. **With HealthKeepers, you choose the level of cost sharing that works for you.**

Here's an example: *Meet Jason**

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

Jason's story

After injuring his knee in a soccer game, Jason chooses a doctor in our network, which saves him the most money. Jason pays a copay or coinsurance based on HealthKeepers negotiated rates because he uses doctors in our network. **Below, see how Jason's benefits work, his treatment costs and why it's important to have health insurance:***

Jason's health plan has the following benefits:

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

The copay applies to the office visit only. Other office services provided during the visit may be subject to deductible and plan coinsurance.

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.

Examples of covered services that apply to the deductible include lab work, X-rays, anesthesia and surgeon fees.

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

- *Doctor visit cost (without insurance):* $200
- *HealthKeepers' negotiated rate:* $140
- *HealthKeepers pays:* $105
- ***Jason paid:*** **$35**

  (This is his plan's copay for primary care doctor office visits.)

Here's what happens when Jason'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
- ***Jason paid:*** **$1,000**

  (Jason's payment counts toward his plan's $2,000 deductible.)

Surgery

- *Hospital/surgery costs (without insurance):* $50,000
- *HealthKeepers' negotiated rate:* $35,000
- ***Jason paid:*** **$1,000**

  (Jason'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 (your percentage of the cost)

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 certain covered services. Having met his deductible, Jason begins to pay coinsurance on covered services that require it.

Let's check in to see Jason's final costs for surgery:

- *Coinsurance* (30% of $34,000): $10,200
- ***Jason paid:*** **$2,965**

(Jason's payment satisfies the remainder of his $5,000 out-of-pocket limit. Even though Jason's coinsurance is 30% or $10,200, he only has to pay a portion of that to meet his $5,000 out-of-pocket limit.)

Out-of-pocket limit

This is the most you pay during a calendar year for covered services. 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.

Jason has met his in-network out-of-pocket limit and the remaining surgery costs are paid by HealthKeepers:

- *HealthKeepers pays:* $31,035
- *Jason's out-of-pocket limit:* $5,000

Summary

Jason paid far less out of pocket because he had health care coverage and stayed in our network. If Jason 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 doctors not in our network with the exception of medically necessary emergency and urgent care.

Let's check in to see Jason's final costs:

- *Total for the doctor visit, MRI and surgery (without health insurance):* $51,700
- *Total HealthKeepers paid after discounts:* $31,140
- ***Total Jason paid:*** **$5,000**

($35 office visit + $2,000 deductible + $2,965 coinsurance = $5,000)

Call your HealthKeepers sales representative for more information.

You can also visit **anthem.com** to view and compare different plans.

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

Qualify for financial help?

With the Affordable Care Act (ACA), most people have to get health care coverage unless they qualify for an exemption. But you may be eligible for financial help to pay for your insurance.

Your medical plan may not cost as much as you think

Depending on your income and family size, you may qualify for an advance premium tax credit (APTC) on any metal level plan, excluding Catastrophic plans, when you buy a plan through the Health Insurance Marketplace. If you qualify, you may be able to enroll in certain Silver plans available on the Health Insurance Marketplace that offer a reduction in the deductible, copays and out-of-pocket costs charged under that plan. This is called a cost-share reduction (CSR) plan (also called cost-sharing subsidy). These options are shown in the chart below as S04, S05 and S06.

Use the chart below to see if you qualify for a cost-share reduction.

1. Find your family size. Then, figure out your yearly income and move across the row to find the income range that applies to your household.

2. Look at the percentage at the top of the chart to see where you fall on the Federal Poverty Level (FPL).

3. Go to the second row to find the plan you qualify for.*

2017 Federal Poverty Level

	Federal Poverty Level	101% - 150%	151% - 200%	201% - 250%
You qualify for		S06	S05	S04
Family Size				
1	$11,880	$11,881-$17,820	$17,821-$23,760	$23,761-$29,700
2	$16,020	$16,021-$24,030	$24,031-$32,040	$32,041-$40,050
3	$20,160	$20,161-$30,240	$30,241-$40,320	$40,321-$50,400
4	$24,300	$24,301-$36,450	$36,451-$48,600	$48,601-$60,750
5	$28,440	$28,441-$42,660	$42,661-$56,880	$56,881-$71,100
6	$32,580	$32,581-$48,870	$48,871-$65,160	$65,161-$81,450
7	$36,730	$36,731-$55,095	$55,096-$73,460	$73,461-$91,825
8	$40,890	$40,891-$61,335	$61,336-$81,780	$81,781-$102,225

Source: Internal data source dated 09/28/2016, calculations based on data from the U.S. Department of Health and Human Services, www.federalregister.gov/documents/2016/01/25/2016-01450/annual-update-of-the-hhs-poverty-guidelines.
* Other metal level plans are available, but are not eligible for a cost-share reduction.

Avoid tax penalties

If you don't enroll in a medical 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 affect you, contact a tax advisor.

What does it mean to shop on or off the Marketplace?

The medical plans you see in this brochure are only available off the Health Insurance Marketplace (your state's Marketplace). If you don't qualify for an APTC or a Silver CSR plan, you may want to shop off the Marketplace at **anthem.com**. We have lots of plans to choose from, and we can help you find one just right for you.

Does the chart show you qualify for a Silver CSR plan? Then, you'll need to shop on the Health Insurance Marketplace. You can still buy an Anthem HealthKeepers plan at **healthcare.gov**, where you can take advantage of an APTC or Silver CSR plan, if you qualify.

Whether you shop on or off the Marketplace, you can compare plans and get a quote on the plan that fits your needs. Contact your HealthKeepers sales representative and ask about our plans.

Overview of plans

Understanding insurance terms

In-network preventive care is covered at no additional cost to you!*

Insurance terms can be confusing. Here's a quick look at some commonly used health insurance terms.

Take a look at the following pages to see the individual and family medical plan choices offered by HealthKeepers, including a sample of commonly used benefits and how they're covered under each plan.

For more information, contact your HealthKeepers sales representative. You can also view and compare plans on anthem.com.

Plan name	Plan name and contract code are found in the first row of the medical plan charts. Look for this when you're applying for a plan. The contract code is in parentheses after the plan name.
Plan includes out-of-network coverage?	Indicates whether the plan includes coverage for out-of-network benefits. **In-network** refers to doctors who are part of the plan's network. **Out-of-network** refers to doctors who don't participate in the network.
Deductible	The **deductible** is a set amount that you pay out of pocket each year before your plan starts paying for covered services, except for in-network preventive services.* *For example:* If your deductible is $5,000, your plan won't pay anything until you've met your $5,000 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 medical plan charts display the individual deductible. Family deductibles are two (2) times the individual amount for most plans and three (3) times the individual amount for Gold plans. **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.
Out-of-pocket limit	The **out-of-pocket** limit is the most you pay during a policy period (each calendar year) before your health insurance or plan pays 100% of the maximum allowed amount. *For example:* If your out-of-pocket limit is $6,850, you will 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 pays 100% of the maximum allowed amount for covered services for the rest of that calendar year. This limit never includes your monthly payment (premium), additional charges from the doctor (balance billing), 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. No one family member pays more than the individual out-of-pocket limit. The medical plan charts display the individual out-of-pocket limit. Family out-of-pocket limits are two (2) times the individual amount.
Coinsurance (coins)	**Your percentage of the cost (Coinsurance/coins)** is the amount you pay for covered health care services. It's a percentage of the cost of services after the deductible has been paid. *For example:* A health plan pays 80% of the maximum allowed amount for a service and you pay the remaining 20%. All medical plans have coinsurance, but the percentage may vary by health care service.
Copay	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 $50, then you pay $50 when you see your in-network doctor — usually at the time you receive treatment. The amount of your copay may depend on the type of health care service you receive.

* Nationally recommended preventive care services from in-network providers have no copay, no coinsurance 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 - POS

Our **POS** plans include out-of-network benefits.

All medical plans include embedded pediatric dental and vision benefits. For more details, see page 20.

	Anthem HealthKeepers Bronze POS 4500 (1GBA)	
Network name	Pathway Tiered Hospital	Pathway Tiered Hospital
	In-network	Out-of-network
Individual deductible[1]	$4,500	$13,500
Individual out-of-pocket limit	$7,150	$21,450
Coinsurance (percentage may vary for some covered services)	30%	50%
Preventive care[2]	No additional cost to you.	Deductible, then 50% coins
Office visit: primary care physician (PCP)[3] (Other office services may be subject to deductible and plan coinsurance)	$35 copay per visit for the first 5 visits, then deductible and 30% coins (combined visit limits for PCP and specialist)	Deductible, then 50% coins
Office visit: specialist (Other office services may be subject to deductible and plan coinsurance)	$65 copay per visit for the first 5 visits, then deductible and 30% coins (combined visit limits for PCP and specialist)	Deductible, then 50% coins
Outpatient diagnostic tests[4] (Ex. X-ray, EKG)	Tier 1: Deductible, then 30% coins Tier 2: Deductible, then 50% coins	Deductible, then 50% coins
Outpatient advanced diagnostic tests[4] (Ex. MRI, CT scan)	Deductible, then 50% coins	Deductible, then 50% coins
Urgent care	Deductible, then 30% coins	Same as In-network
Emergency room care	Deductible, then 50% coins	Same as In-network
Hospital: inpatient admission[4] (includes maternity, mental health / substance use)	Tier 1: Deductible, then 30% coins Tier 2: Deductible, then 50% coins	Deductible, then 50% coins
Hospital: outpatient surgery hospital facility[4] (includes maternity)	Tier 1: Deductible, then 30% coins Tier 2: Deductible, then 50% coins	Deductible, then 50% coins
Pharmacy deductible (for tiers with deductible, cost share applies after deductible)	Tier 1: No deductible Tier 2, 3, 4: Medical deductible applies	Tier 1, 2, 3, 4: Medical deductible applies
Retail pharmacy tier 1	$25 copay	50% coins
Retail pharmacy tier 2	50% coins	50% coins
Retail pharmacy tier 3	50% coins	50% coins
Retail pharmacy tier 4	50% coins	50% coins
Mental health / substance use: outpatient facility & services[4]	Tier 1: Deductible, then 30% coins Tier 2: Deductible, then 50% coins	Deductible, then 50% coins

Please see Medical plans footnotes on page 19.

Medical plans - POS

Our **POS** plans include out-of-network benefits.

All medical plans include embedded pediatric dental and vision benefits. For more details, see page 20.

	Anthem HealthKeepers Bronze POS 5750 for HSA (1X55)	
Network name	Pathway Tiered Hospital	Pathway Tiered Hospital
	In-network	Out-of-network
Individual deductible[1]	$5,750	$17,250
Individual out-of-pocket limit	$6,550	$19,650
Coinsurance (percentage may vary for some covered services)	0%	50%
Preventive care[2]	No additional cost to you.	Deductible, then 50% coins
Office visit: primary care physician (PCP)[3] (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 0% coins	Deductible, then 50% coins
Office visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 0% coins	Deductible, then 50% coins
Outpatient diagnostic tests[4] (Ex. X-ray, EKG)	Tier 1: Deductible, then 0% coins Tier 2: Deductible, then 30% coins	Deductible, then 50% coins
Outpatient advanced diagnostic tests[4] (Ex. MRI, CT scan)	Deductible, then 50% coins	Deductible, then 50% coins
Urgent care	Deductible, then 0% coins	Same as In-network
Emergency room care	Deductible, then 20% coins	Same as In-network
Hospital: inpatient admission[4] (includes maternity, mental health / substance use)	Tier 1: Deductible, then 0% coins Tier 2: Deductible, then 30% coins	Deductible, then 50% coins
Hospital: outpatient surgery hospital facility[4] (includes maternity)	Tier 1: Deductible, then 0% coins Tier 2: Deductible, then 30% coins	Deductible, then 50% coins
Pharmacy deductible (for tiers with deductible, cost share applies after deductible)	Tier 1, 2, 3, 4: Medical deductible applies	Tier 1, 2, 3, 4: Medical deductible applies
Retail pharmacy tier 1	20% coins	50% coins
Retail pharmacy tier 2	20% coins	50% coins
Retail pharmacy tier 3	50% coins	50% coins
Retail pharmacy tier 4	50% coins	50% coins
Mental health / substance use: outpatient facility & services[4]	Deductible, then 0% coins	Deductible, then 50% coins

Please see Medical plans footnotes on page 19.

Medical plans - POS

Our **POS** plans include out-of-network benefits.

All medical plans include embedded pediatric dental and vision benefits. For more details, see page 20.

	Anthem HealthKeepers Silver POS 2300 (1GBF)	
Network name	Pathway Tiered Hospital	Pathway Tiered Hospital
	In-network	Out-of-network
Individual deductible[1]	$2,300	$6,900
Individual out-of-pocket limit	$7,150	$21,450
Coinsurance (percentage may vary for some covered services)	20%	50%
Preventive care[2]	No additional cost to you.	Deductible, then 50% coins
Office visit: primary care physician (PCP)[3] (Other office services may be subject to deductible and plan coinsurance)	$20 copay per visit for the first 5 visits, then deductible and 20% coins (combined visit limits for PCP and specialist)	Deductible, then 50% coins
Office visit: specialist (Other office services may be subject to deductible and plan coinsurance)	$65 copay per visit for the first 5 visits, then deductible and 20% coins (combined visit limits for PCP and specialist)	Deductible, then 50% coins
Outpatient diagnostic tests[4] (Ex. X-ray, EKG)	Tier 1: Deductible, then 20% coins Tier 2: Deductible, then 50% coins	Deductible, then 50% coins
Outpatient advanced diagnostic tests[4] (Ex. MRI, CT scan)	Deductible, then 50% coins	Deductible, then 50% coins
Urgent care	Deductible, then 20% coins	Same as In-network
Emergency room care	Deductible, then 40% coins	Same as In-network
Hospital: inpatient admission[4] (includes maternity, mental health / substance use)	Tier 1: Deductible, then 20% coins Tier 2: Deductible, then 50% coins	Deductible, then 50% coins
Hospital: outpatient surgery hospital facility[4] (includes maternity)	Tier 1: Deductible, then 20% coins Tier 2: Deductible, then 50% coins	Deductible, then 50% coins
Pharmacy deductible (for tiers with deductible, cost share applies after deductible)	Tier 1, 2: No deductible Tier 3, 4: Medical deductible applies	Tier 1, 2, 3, 4: Medical deductible applies
Retail pharmacy tier 1	$20 copay	50% coins
Retail pharmacy tier 2	$50 copay	50% coins
Retail pharmacy tier 3	50% coins	50% coins
Retail pharmacy tier 4	50% coins	50% coins
Mental health / substance use: outpatient facility & services[4]	Tier 1: Deductible, then 20% coins Tier 2: Deductible, then 50% coins	Deductible, then 50% coins

Please see Medical plans footnotes on page 19.

Medical plans - HMO

The benefit information shown here is for in-network services. Our **HMO** plans only include out-of-network benefits for emergency care, urgent care and ambulance services.
All medical plans include embedded pediatric dental and vision benefits. For more details, see page 20.

	Anthem HealthKeepers Bronze 4900 for HSA (1GBB)	Anthem HealthKeepers Bronze 5150 (1GB9)	Anthem HealthKeepers Bronze 5900 (1GB8)
Network name	Pathway Tiered Hospital	Pathway Tiered Hospital	Pathway Tiered Hospital
Plan includes out-of-network coverage?	No	No	No
Individual deductible[1]	$4,900	$5,150	$5,900
Individual out-of-pocket limit	$6,550	$7,150	$7,150
Coinsurance (percentage may vary for some covered services)	35%	35%	35%
Preventive care[2]	No additional cost to you.	No additional cost to you.	No additional cost to you.
Office visit: primary care physician (PCP)[3] (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 35% coins	$45 copay per visit for the first 3 visits, then deductible and 35% coins	$40 copay per visit for the first 2 visits, then deductible and 35% coins
Office visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 35% coins	Deductible, then 35% coins	Deductible, then 35% coins
Outpatient diagnostic tests[4] (Ex. X-ray, EKG)	Tier 1: Deductible, then 35% coins Tier 2: Deductible, then 50% coins	Tier 1: Deductible, then 35% coins Tier 2: Deductible, then 50% coins	Tier 1: Deductible, then 35% coins Tier 2: Deductible, then 50% coins
Outpatient advanced diagnostic tests[4] (Ex. MRI, CT scan)	Deductible, then 50% coins	Deductible, then 50% coins	Deductible, then 50% coins
Urgent care	Deductible, then 35% coins	Deductible, then 35% coins	Deductible, then 35% coins
Emergency room care	Deductible, then 50% coins	Deductible, then 50% coins	Deductible, then 50% coins
Hospital: inpatient admission[4] (includes maternity, mental health / substance use)	Tier 1: Deductible, then 35% coins Tier 2: Deductible, then 50% coins	Tier 1: Deductible, then 35% coins Tier 2: Deductible, then 50% coins	Tier 1: Deductible, then 35% coins Tier 2: Deductible, then 50% coins
Hospital: outpatient surgery hospital facility[4] (includes maternity)	Tier 1: Deductible, then 35% coins Tier 2: Deductible, then 50% coins	Tier 1: Deductible, then 35% coins Tier 2: Deductible, then 50% coins	Tier 1: Deductible, then 35% coins Tier 2: Deductible, then 50% coins
Pharmacy deductible (for tiers with deductible, cost share applies after deductible)	Tier 1, 2, 3, 4: Medical deductible applies	Tier 1, 2, 3, 4: Medical deductible applies	Tier 1, 2, 3, 4: Medical deductible applies
Retail pharmacy tier 1	35% coins	35% coins	35% coins
Retail pharmacy tier 2	35% coins	50% coins	35% coins
Retail pharmacy tier 3	50% coins	50% coins	50% coins
Retail pharmacy tier 4	50% coins	50% coins	50% coins
Mental health / substance use: outpatient facility & services[4]	Deductible, then 35% coins	Tier 1: Deductible, then 35% coins Tier 2: Deductible, then 50% coins	Tier 1: Deductible, then 35% coins Tier 2: Deductible, then 50% coins

Please see Medical plans footnotes on page 19.

Medical plans - HMO

The benefit information shown here is for in-network services. Our **HMO** plans only include out-of-network benefits for emergency care, urgent care and ambulance services.
All medical plans include embedded pediatric dental and vision benefits. For more details, see page 20.

	Anthem HealthKeepers Bronze 6200 for HSA (1GB7)	Anthem HealthKeepers Bronze 6350 (2EUK) †	Anthem HealthKeepers Silver 1800 (1GBG)
Network name	Pathway Tiered Hospital	Pathway Tiered Hospital	Pathway Tiered Hospital
Plan includes out-of-network coverage?	No	No	No
Individual deductible[1]	$6,200	$6,350	$1,800
Individual out-of-pocket limit	$6,550	$7,150	$7,150
Coinsurance (percentage may vary for some covered services)	25%	40%	30%
Preventive care[2]	No additional cost to you.	No additional cost to you.	No additional cost to you.
Office visit: primary care physician (PCP)[3] (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 25% coins	Deductible, then 40% coins	$35 copay per visit for the first 3 visits, then deductible and 30% coins
Office visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 25% coins	Deductible, then 40% coins	Deductible, then 30% coins
Outpatient diagnostic tests[4] (Ex. X-ray, EKG)	Tier 1: Deductible, then 25% coins Tier 2: Deductible, then 50% coins	Tier 1: Deductible, then 40% coins Tier 2: Deductible, then 50% coins	Tier 1: Deductible, then 30% coins Tier 2: Deductible, then 50% coins
Outpatient advanced diagnostic tests[4] (Ex. MRI, CT scan)	Deductible, then 50% coins	Deductible, then 50% coins	Deductible, then 50% coins
Urgent care	Deductible, then 25% coins	Deductible, then 40% coins	Deductible, then 30% coins
Emergency room care	Deductible, then 45% coins	Deductible, then 50% coins	Deductible, then 50% coins
Hospital: inpatient admission[4] (includes maternity, mental health / substance use)	Tier 1: Deductible, then 25% coins Tier 2: Deductible, then 50% coins	Tier 1: Deductible, then 40% coins Tier 2: Deductible, then 50% coins	Tier 1: Deductible, then 30% coins Tier 2: Deductible, then 50% coins
Hospital: outpatient surgery hospital facility[4] (includes maternity)	Tier 1: Deductible, then 25% coins Tier 2: Deductible, then 50% coins	Tier 1: Deductible, then 40% coins Tier 2: Deductible, then 50% coins	Tier 1: Deductible, then 30% coins Tier 2: Deductible, then 50% coins
Pharmacy deductible (for tiers with deductible, cost share applies after deductible)	Tier 1, 2, 3, 4: Medical deductible applies	Tier 1, 2, 3, 4: Medical deductible applies	Tier 1, 2: No deductible Tier 3, 4: Medical deductible applies
Retail pharmacy tier 1	25% coins	40% coins	$20 copay
Retail pharmacy tier 2	25% coins	40% coins	$50 copay
Retail pharmacy tier 3	50% coins	50% coins	50% coins
Retail pharmacy tier 4	50% coins	50% coins	50% coins
Mental health / substance use: outpatient facility & services[4]	Deductible, then 25% coins	Deductible, then 40% coins	Tier 1: Deductible, then 30% coins Tier 2: Deductible, then 50% coins

Please see Medical plans footnotes on page 19.

Medical plans - HMO

The benefit information shown here is for in-network services. Our **HMO** plans only include out-of-network benefits for emergency care, urgent care and ambulance services.
All medical plans include embedded pediatric dental and vision benefits. For more details, see page 20.

	Anthem HealthKeepers Silver 2800 (1GBD)	Anthem HealthKeepers Silver 3500 (1GBC)	Anthem HealthKeepers Silver 5000 (2EUL) †
Network name	Pathway Tiered Hospital	Pathway Tiered Hospital	Pathway Tiered Hospital
Plan includes out-of-network coverage?	No	No	No
Individual deductible[1]	$2,800	$3,500	$5,000
Individual out-of-pocket limit	$7,150	$7,150	$6,750
Coinsurance (percentage may vary for some covered services)	20%	15%	25%
Preventive care[2]	No additional cost to you.	No additional cost to you.	No additional cost to you.
Office visit: primary care physician (PCP)[3] (Other office services may be subject to deductible and plan coinsurance)	$35 copay per visit for the first 3 visits, then deductible and 20% coins	$45 copay	$30 copay
Office visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 20% coins	Deductible, then 15% coins	Deductible, then 25% coins
Outpatient diagnostic tests[4] (Ex. X-ray, EKG)	Tier 1: Deductible, then 20% coins Tier 2: Deductible, then 50% coins	Tier 1: Deductible, then 15% coins Tier 2: Deductible, then 45% coins	Tier 1: Deductible, then 25% coins Tier 2: Deductible, then 50% coins
Outpatient advanced diagnostic tests[4] (Ex. MRI, CT scan)	Deductible, then 50% coins	Deductible, then 50% coins	Deductible, then 50% coins
Urgent care	Deductible, then 20% coins	Deductible, then 15% coins	Deductible, then 25% coins
Emergency room care	Deductible, then 40% coins	Deductible, then 35% coins	Deductible, then 45% coins
Hospital: inpatient admission[4] (includes maternity, mental health / substance use)	Tier 1: Deductible, then 20% coins Tier 2: Deductible, then 50% coins	Tier 1: Deductible, then 15% coins Tier 2: Deductible, then 45% coins	Tier 1: Deductible, then 25% coins Tier 2: Deductible, then 50% coins
Hospital: outpatient surgery hospital facility[4] (includes maternity)	Tier 1: Deductible, then 20% coins Tier 2: Deductible, then 50% coins	Tier 1: Deductible, then 15% coins Tier 2: Deductible, then 45% coins	Tier 1: Deductible, then 25% coins Tier 2: Deductible, then 50% coins
Pharmacy deductible (for tiers with deductible, cost share applies after deductible)	Tier 1, 2: No deductible Tier 3, 4: Medical deductible applies	Tier 1, 2: No deductible Tier 3, 4: Medical deductible applies	Tier 1, 2: No deductible Tier 3, 4: Medical deductible applies
Retail pharmacy tier 1	$20 copay	$20 copay	$10 copay
Retail pharmacy tier 2	$50 copay	$50 copay	$40 copay
Retail pharmacy tier 3	50% coins	50% coins	50% coins
Retail pharmacy tier 4	50% coins	50% coins	50% coins
Mental health / substance use: outpatient facility & services[4]	Tier 1: Deductible, then 20% coins Tier 2: Deductible, then 50% coins	Tier 1: Deductible, then 15% coins Tier 2: Deductible, then 45% coins	Tier 1: Deductible, then 25% coins Tier 2: Deductible, then 50% coins

Please see Medical plans footnotes on page 19.

Medical plans - HMO

The benefit information shown here is for in-network services. Our **HMO** plans only include out-of-network benefits for emergency care, urgent care and ambulance services.
All medical plans include embedded pediatric dental and vision benefits. For more details, see page 20.

	Anthem HealthKeepers Gold 1000 (1GBJ)	Anthem HealthKeepers Gold 1300 (2ETV)	Anthem HealthKeepers Catastrophic 7150 (1GB6)
Network name	Pathway Tiered Hospital	Pathway Tiered Hospital	Pathway Tiered Hospital
Plan includes out-of-network coverage?	No	No	No
Individual deductible[1]	$1,000	$1,300	$7,150
Individual out-of-pocket limit	$5,000	$4,800	$7,150
Coinsurance (percentage may vary for some covered services)	20%	20%	0%
Preventive care[2]	No additional cost to you.	No additional cost to you.	No additional cost to you.
Office visit: primary care physician (PCP)[3] (Other office services may be subject to deductible and plan coinsurance)	$35 copay	$20 copay	$40 copay per visit for the first 3 visits, then deductible and 0% coins
Office visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 20% coins	$50 copay	Deductible, then 0% coins
Outpatient diagnostic tests[4] (Ex. X-ray, EKG)	Tier 1: Deductible, then 20% coins Tier 2: Deductible, then 50% coins	Tier 1: Deductible, then 20% coins Tier 2: Deductible, then 50% coins	Deductible, then 0% coins
Outpatient advanced diagnostic tests[4] (Ex. MRI, CT scan)	Deductible, then 50% coins	Deductible, then 50% coins	Deductible, then 0% coins
Urgent care	Deductible, then 20% coins	Deductible, then 20% coins	Deductible, then 0% coins
Emergency room care	Deductible, then 40% coins	Deductible, then 40% coins	Deductible, then 0% coins
Hospital: inpatient admission[4] (includes maternity, mental health / substance use)	Tier 1: Deductible, then 20% coins Tier 2: Deductible, then 50% coins	Tier 1: Deductible, then 20% coins Tier 2: Deductible, then 50% coins	Deductible, then 0% coins
Hospital: outpatient surgery hospital facility[4] (includes maternity)	Tier 1: Deductible, then 20% coins Tier 2: Deductible, then 50% coins	Tier 1: Deductible, then 20% coins Tier 2: Deductible, then 50% coins	Deductible, then 0% coins
Pharmacy deductible (for tiers with deductible, cost share applies after deductible)	Tier 1, 2: No deductible Tier 3, 4: Medical deductible applies	Tier 1, 2: No deductible Tier 3, 4: Medical deductible applies	Tier 1, 2, 3, 4: Medical deductible applies
Retail pharmacy tier 1	$15 copay	$15 copay	0% coins
Retail pharmacy tier 2	$50 copay	$40 copay	0% coins
Retail pharmacy tier 3	50% coins	50% coins	0% coins
Retail pharmacy tier 4	50% coins	50% coins	0% coins
Mental health / substance use: outpatient facility & services[4]	Tier 1: Deductible, then 20% coins Tier 2: Deductible, then 50% coins	Tier 1: Deductible, then 20% coins Tier 2: Deductible, then 50% coins	Deductible, then 0% coins

Please see Medical plans footnotes on page 19.

Medical plans benefit footnotes

† New plan for 2017

1 The medical plan charts display the **individual deductible**. **Family deductibles** are two (2) times the individual amount for most plans and three (3) times the individual amount for Gold plans.
2 Nationally recommended **preventive care services** from in-network providers have no copay, no coinsurance 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.
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 and facilities in our network, unless cost shares are the same for both tiers.

Embedded pediatric dental benefits

Embedded pediatric dental benefits are included with all of our medical plans for members until the end of the month in which they turn 19. Coverage includes preventive care, fillings and some other major services like dentally necessary orthodontia.

- Shared deductible for medical and dental services except for dental diagnostic and preventive services on most plans
- Shared out-of-pocket limit for medical and dental services

	Medical plans[1]	**Catastrophic medical plans**
	in-network / out-of-network[2]	***in-network / out-of-network***[2]
Dental network	Dental Prime	Dental Prime
Deductible	Dental services subject to the medical deductible except diagnostic and preventive services	All dental services subject to the medical deductible
Annual maximum (per person)	None	None
Annual out-of-pocket limit	Combined with medical	Combined with medical
Diagnostic and preventive	*No waiting period*	*No waiting period*
Cleaning, exams, x-rays	0% / 30% coinsurance	0% / 0% coinsurance
Basic services	*No waiting period*	*No waiting period*
Fillings	40% / 50% coinsurance	0% / 0% coinsurance
Complex and major services	*No waiting period*	*No waiting period*
Endodontic/periodontic/oral surgery	50% / 50% coinsurance	0% / 0% coinsurance
Major services	50% / 50% coinsurance	0% / 0% coinsurance
Dentally necessary orthodontia[3]	50% / 50% coinsurance	0% / 0% coinsurance
Cosmetic orthodontia	Not covered	Not covered

1 For medical plans where the deductible equals the out-of-pocket limit, any services subject to the deductible have coinsurance of 0% after deductible.
2 The out-of-network pediatric dental benefits displayed only apply if the medical plan provides for out-of-network coverage.
3 Orthodontia is usually considered dentally necessary when a child's teeth are misaligned (crooked or not spaced correctly) to the point where they don't work properly. This could cause the child to have trouble speaking or eating. Some examples would be (1) if a child can't bite into an apple because they can't close their front teeth together or (2) if a child bites into the gum tissue of the palate (roof of the mouth) when they try to bite down.

Embedded pediatric vision benefits

The following vision care services are covered for members until the end of the month in which they turn 19. Coverage may include eye exams, eye glass lenses, frames and contact lenses. The benefit period is the calendar year (January 1 through December 31).

- If you purchase a Catastrophic plan, you must meet your medical deductible before pediatric vision benefits are paid.
- Out-of-network providers may bill you for any charges that exceed the plan's maximum allowed amount.
- The out-of-network pediatric vision benefits displayed only apply if the medical plan provides for out-of-network coverage.

	Benefit frequency	**Cost share** ***in-network / out-of-network***
Eye exam	Once every benefit period	$0 copay / $0 copay up to maximum allowed amount
Lenses (single, biofocal, trifocal and standard progressive)	Once every benefit period	$0 copay / $0 copay up to maximum allowed amount
Frames	Once every benefit period	Anthem formulary[1] / $0 copay up to maximum allowed amount
Contact lenses (Non-elective)	Once every benefit period[2]	Covered in full / $0 copay up to maximum allowed amount
Contact lenses (Elective/disposable)	Once every benefit period[2]	Anthem formulary[1] / $0 copay up to maximum allowed amount
Low vision services (reading and computer glasses)	Once every benefit period	$0 copay / Not covered (benefits are only available when received from Blue View Vision providers)

1 A collection of frames and lenses that can be purchased for a $0 copay (may differ by provider).

2 Benefits for contact lenses are in lieu of the eyeglass lens benefit. If you receive contact lenses, no benefit will be available for eyeglass lenses until the next benefit period.

Dental

Anthem Blue Cross and Blue Shield (Anthem) offers a variety of individual and family dental plans to fit your health care needs and budget:

- Dental Prime*
- Anthem Dental Family Value
- Anthem Dental Family
- Anthem Dental Family Enhanced

Anthem can help you get access to the dental care you need for your overall health. Many of our dental plans cover you 100% for exams, cleanings and X-rays. Plus, we have one of the largest dental preferred provider organization (PPO) networks in the country. To see more of what we cover, take a look at our **Dental stand-alone plans** on the next page.

Tools that put a smile on your face

We offer some great online tools to help you better understand your dental health. Once you're a member, log in to the web address on your ID card to access:

Ask a Hygienist

Email questions to licensed dental professionals and get quick, private personalized advice at no extra cost.

Dental Cost Estimator

Help estimate your costs for certain dental procedures and services in the ZIP code where you get care.

Dental Health Assessment

Get feedback based on your unique responses to a few questions to help you keep a healthy smile.

Vision

You can add Blue View Vision℠ benefits to any HealthKeepers medical or Anthem dental plan. These plans feature:

- **A broad national network** — More than 33,000 participating private practice doctors† at over 26,000 locations, including online choices at Glasses.com, ContactsDirect or 1-800 CONTACTS plus leading retail stores like LensCrafters®, Sears Optical℠, Target Optical®, JCPenney® Optical and most Pearle Vision® locations — these stores offer evening and weekend hours.
- **Value-added savings§** — 15% to 40% off unlimited purchases of most extra pairs of eyewear, conventional contact lenses, lens treatments and more — even after you've used all of your covered benefits.

	Benefit frequency	Cost Share
Eye exam (with dilation as needed)	Once every 12 months	$20 copay
Standard plastic (CR39) lenses:±	Once every 24 months	
Single vision		$20 copay
Bifocal		$20 copay
Trifocal		$20 copay
Contact lenses:	Once every 24 months	
Elective (conventional and disposable)		$80 allowance
Non-elective		Covered in full
Frames	Once every 24 months	$130 allowance

± Factory scratch coating is covered at no extra cost. Polycarbonate and Transitions lenses are covered for dependents.

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.

* Does not include ACA required pediatric dental essential health benefits coverage.
† Blue View Vision internal data, 2015.
§ Laws in some states may prohibit in-network providers from discounting products and services that are not covered benefits.

Dental stand-alone plans

	Anthem Dental Family Value (Dependents age 18 and younger)	**Anthem Dental Family Value** (Adults age 19+)	**Anthem Dental Family** (Dependents age 18 and younger)	**Anthem Dental Family** (Adults age 19+)	**Anthem Dental Family Enhanced** (Dependents age 18 and younger)	**Anthem Dental Family Enhanced** (Adults age 19+)
	In-network / Out-of-network	**In-network / Out-of-network**	**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	Dental Prime	Dental Prime
Deductible (per person, all services)	$50	$50	$50	$50	$25	$50
Annual Maximum (per person)	None	$750	None	$750	None	$1,000
Annual out-of-pocket limit	$350[1] / None	None	$350[1] / None	None	$350[1] / None	None
Diagnostic and preventive	No waiting period	No waiting period	No waiting period	No waiting period	No waiting period	No waiting period
Cleaning, exams and x-rays	0% / 30% coinsurance	0% / 50% coinsurance	0% / 30% coinsurance	0% / 50% coinsurance	0% / 20% coinsurance	0% / 50% coinsurance
Extra cleaning	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Basic services	No waiting period	6-month waiting period	No waiting period	6-month waiting period	No waiting period	6-month waiting period
Fillings	40% / 50% coinsurance	50% / 75% coinsurance	40% / 50% coinsurance	50% / 75% coinsurance	20% / 40% coinsurance	20% / 60% coinsurance
Brush biopsy	Not covered	Covered[2]	Not covered	Covered[2]	Not covered	Covered[2]
Complex & major services	No waiting period	Not covered	No waiting period	12-month waiting period	No waiting period[3]	12-month waiting period
Endodontic/periodontic/oral surgery (root canal, scaling, tooth removal)	50% / 50% coinsurance	Not covered	50% / 50% coinsurance	70% / 85% coinsurance	20% / 50% coinsurance	50% / 75% coinsurance
Prosthetics (crowns, dentures, bridges)	50% / 50% coinsurance	Not covered	50% / 50% coinsurance	70% / 85% coinsurance	50% / 50% coinsurance	50% / 75% coinsurance
Medically necessary orthodontia	50% / 50% coinsurance	Not covered	50% / 50% coinsurance	Not covered	50% / 50% coinsurance	Not covered
Cosmetic orthodontia	Not covered	Not covered	Not covered	Not covered	50% / 50% coinsurance[4]	Not covered
International emergency dental program	Included	Included	Included	Included	Included	Included
Blue View Vision	Available	Available	Available	Available	Available	Available

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

1 Per child, up to $700 per family.

2 Covered for adults age 20 and older.
3 Except 12-month waiting period for **Cosmetic orthodontia**.
4 $1,000 lifetime maximum for **Cosmetic orthodontia.**

Dental plans underwritten by Anthem Blue Cross and Blue Shield.

Dental stand-alone plans

	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**
Dental network	Dental Prime	Dental Prime	Dental Prime
Deductible (per person, all services)	None	$50	$50
Annual Maximum (per person)	$500	$1,000	$1,250
Annual out-of-pocket limit	None	None	None
Diagnostic and preventive	No waiting period	No waiting period	No waiting period
Cleaning, exams and x-rays	0% / 0% coinsurance	0% / 0% coinsurance	0% / 0% coinsurance
Extra cleaning	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	Not covered	6-month waiting period	6-month waiting period
Fillings	Not covered	20% / 20% coinsurance	20% / 20% coinsurance
Brush biopsy	Not covered	20% / 20% coinsurance	20% / 20% coinsurance
Complex & major services	Not covered	12-month waiting period	12-month waiting period
Endodontic/periodontic/oral surgery (root canal, scaling, tooth removal)	Not covered	50% / 50% coinsurance	50% / 50% coinsurance
Prosthetics (crowns, dentures, bridges)	Not covered	Not covered	50% / 50% coinsurance
Medically necessary orthodontia	Not covered	Not covered	Not covered
Cosmetic orthodontia	Not covered	Not covered	Not covered
International emergency dental program	Included	Included	Included
Blue View Vision	Available	Available	Available

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

1 Per child, up to $700 per family.

2 Covered for adults age 20 and older.
3 Except 12-month waiting period for **Cosmetic orthodontia**.
4 $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 plan — 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 resources

Whether you're looking for one-on-one coaching or pregnancy 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 — is staffed with registered nurses who are just a phone call away at any time. Nurses can answer questions about a medical concern or help you choose the right level of care. Plus, you can call the same phone line and listen to hundreds of health topics in the AudioHealth Library.

Care Support — gives you the extra care and support you need for your ongoing or complex health issues. A case manager may call you to see how we can help keep your condition in check and give you information as well as emotional support services.

And don't forget about those regular checkups! Your yearly exams, flu shots and other preventive care services are covered 100% when you visit in-network providers. These services can give you extra support in managing your health or a specific health condition.

MyHealth Advantage — helps keep you healthier. We review your incoming health claims and remind you if you've missed a routine test or checkup. We also check the medications you take in the event your doctor needs to be alerted of possible drug interactions or if you could save money. If we find something that can help you, we'll mail you a confidential MyHealth Note. Or, download the Anthem Anywhere app and choose to receive your personalized, secure health messages on-the-go through the Mobile Inbox.

SpecialOffers@Anthem℠

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

Through the program, members can 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**.

* 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 (EHPC) is a 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:

- Helps to improve 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.

To find out if your primary care doctor is in the EPHC program, go to **anthem.com/findadoctor**. If your doctor is in the program, you'll see Quality Snapshot within the doctor's listing and the EPHC designation (a heart symbol with a plus sign) under Other Certifications.

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

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.

Our secure website:

- 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.
- Manage your prescription benefits and search the drug list that applies to your benefit plan.

Our Anthem Anywhere app:

- Find a doctor, hospital or pharmacy
- Get a virtual ID card
- Compare doctor costs and quality
- Manage prescription benefits
- View claims

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

Now you can have a private video visit with a doctor or therapist on your smartphone, tablet or computer. LiveHealth Online* is an easy and convenient way to get the care you need from the comfort and privacy of home.

All you have to do is sign up at **livehealthonline.com** to use it!

- Get medical advice, diagnoses, proper treatment and even prescriptions, 24/7 in about 10 minutes or less
- Quickly address common health problems, like allergies, colds, rashes, fever and more

Now, you can talk to a licensed therapist or psychologist at home. If you're feeling stressed, worried or having a tough time, we're here to help.

- See a therapist in four days or less†
- Choose a time that's convenient for you - seven days a week from 7 a.m. to 11 p.m.

Doctors typically charge $49 or less per visit and therapists usually cost the same as what you'd pay for an office therapy visit, depending on your medical plan.‡

Register at anthem.com for online access.

Once you're a member, register at **anthem.com** to access your benefits online. And don't forget to download the **Anthem Anywhere** mobile app, so you can manage your benefits at home or on the go.

* LiveHealth Online is the trade name of the Health Management Corporation.
† Appointments subject to availability of a therapist. Psychologists or therapists using LiveHealth Online cannot prescribe medications.
‡ Depending on your coverage, the cost may be similar to what you would pay for an office visit, considering your benefits, copay or coinsurance.

Ready to enroll? Let's get started.

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:

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

Then, you can:

4. **Call your sales representative** to enroll or learn more about our health care plans. Take a look at the application included with this brochure.
5. **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, 2016 through January 31, 2017. Be sure to enroll by December 15, 2016, to start coverage effective January 1, 2017.

There are special qualifying events that may allow you to change your health coverage outside of the open enrollment period. Check with your HealthKeepers sales representative to see if you qualify or if you have other questions about open enrollment.

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

Simplified payments

You can set up a recurring payment using electronic funds transfer (EFT) or bank draft, which means your premium will automatically be paid from your bank account each month.

You can also use WebPay to make your monthly payments. This payment program allows you to enroll in automatic recurring payments with a Visa or MasterCard debit or credit card.

If you choose to make regular credit card payments, make sure your card's expiration date and other account information stays up to date.

We want you to be satisfied

After you enroll in one of our plans, you'll have access to an *Evidence of Coverage* that explains the 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 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 cost and complete details on what's covered and what isn't:

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

To access a ***Summary of Benefits and Coverage (SBC)***, please visit **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
- Premiums
- Deductibles, copays, coinsurance and out-of-pocket limits

There may also be changes to our prescription formulary/drug list, and pharmacy and provider networks during the year.

Still have questions?

Please reach out to your 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 legal 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 don't 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 triggered 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 Review

Utilization review 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 utilization 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 utilization 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 utilization 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 pre-service review (done before you get medical care)

We may do a pre-service 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 pre-service 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
- 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, such as physical therapy or durable medical equipment. The utilization review team looks at the member's medical information at the time of the review to see if the treatment is medically necessary.

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

We do a post-service review when you have already had surgery or another type of medical care. When the utilization 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 management is conducted by a licensed health care professional, who works with you and your doctor to help you learn about and manage your health conditions. They also help you better understand your health benefits.

Precertification

Precertification 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 precertification guidelines regularly. Precertification is a type of pre-service review.

Here's how getting precertification can help you out:

Saving time. Preauthorizing services is a process of verifying, in advance, whether a proposed treatment, service or supply is medically necessary and/or medically appropriate. The doctors in our network ask for prior authorization 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 an in-network doctor. Talk to your doctor about your conditions and treatment options. Ask your doctor which covered services need prior authorization or call us to ask. The doctor's office will ask for prior authorization 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 prior authorization. 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. Once you're a member, if you have a question about prior authorization, you can call the Member Service number on the back of 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 may be covered, 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 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 Participating (PAR) network, outside of HealthKeepers' service area, will be covered at the out-of-network cost shares, but you will be protected from balance billing.

BlueCard Program is only available outside HealthKeepers' service area.

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. When you use BlueCard providers in the PAR network, you will be protected from balance billing.

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 for rehabilitation services and 30 visits for spinal manipulation per member per year for habilitation services
- 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 for rehabilitation services and 30 combined visits per member per year for habilitation services
  - Speech therapy - 30 visits per member per year for rehabilitation services and 30 visits per member per year for habilitation services

Limitations – Embedded pediatric dental benefits, Anthem Dental Family Value, Anthem Dental Family and Anthem Dental Family Enhanced Benefits for Pediatric Members up to age 19

Diagnostic and Preventive Services

- **Oral Exams** - covered 2 times every 12 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 12 months.
  - 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 2 times per 12 months.
- **Space Maintainers** - covered once per 24-month period per tooth per quadrant (unilateral) per arch (bilateral). Repair or replacement of lost/broken appliances are not a covered benefit.

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. Covered per primary teeth only. Will not be covered if billed with root canal therapy.
- **Pulpal therapy** - covered once per tooth per lifetime. Covered per primary teeth only.
- **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** - covered once per tooth per lifetime.
- **Retrograde filling** - covered once per tooth per lifetime.
- **Apexification** - covered once per tooth per lifetime. Coverage includes initial visit, interim medication replacement (limited to 3 treatments) and the final visit.

Periodontal Services

- **Periodontal scaling & root planning** - covered once per quadrant per 24 months.
- **Crown Lengthening** - covered once per tooth per lifetime.
- **Full Mouth Debridement** - covered once per 12 months.
- **Osseous Surgery** - covered once per quadrant per 60 months.
- **Gingivectomy or gingivoplasty** - covered once per 24 month-period per quadrant.
- **Emergency room services provided by dentist** - covered only for occlusal orthotic devices.

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).
- **Alveoplasty** - covered once per quadrant per lifetime.
- **Frenulectomy/Frenuloplasty** - covered once per lifetime.

Major Restorative Services

- **Pre-fabricated, Stainless Steel, or Temporary Crown** - covered as needed per pathology. 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 months. Only covered on a permanent tooth. To be covered, the tooth must have extensive loss of natural structure due to decay or fracture so that another restoration (such as a filling or inlay) cannot be used to restore the tooth. We'll pay up to the maximum allowed amount for one of the following types of crowns: high noble metal, porcelain only or metal/porcelain. If you choose to have another type of crown, you're responsible to pay for the difference plus any applicable deductible and coinsurance.
- **Labial Veneers** - covered one per 60 months per tooth. This is considered as an alternate treatment to a full restoration for an endodontically treated tooth.

Prosthodontic Services

- **Removable Prosthetic Services (Dentures and Partials)** - covered 1 time per 60-month period for the replacement of extracted permanent teeth. If you have an existing denture or partial, a replacement is only covered if at least 60 months have passed and it cannot be repaired or adjusted.
- **Fixed Prosthetic Services (Bridge)** - covered 1 time per 5 years for the replacement of extracted permanent teeth. If you have an existing bridge, a replacement is only covered if at least 60 months has passed and it cannot be repaired or adjusted. The plan will cover the least costly, commonly performed course of treatment. If there are multiple missing teeth, the plan may cover a partial denture instead of the bridge. If you still choose to get the bridge, you will be responsible to pay the difference in cost, plus any applicable deductible and coinsurance.
- **Denture adjustments** - not covered within 6 months of placement.
- **Reline denture (chair or laboratory)** - covered once per 3 years as long as the appliance (denture, partial or bridge) is the permanent appliance, not covered within 6 months of placement.
- **Occlusal Orthotic Device** - covered only for temporomandibular pain, dysfunction or associated musculature.

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

Limitations - Anthem Dental Family Value, Anthem Dental Family and Anthem Family Enhanced benefits for Adult Members

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.

Limitations – Embedded pediatric vision benefits

- **Routine Eye Exam** - covered once per calendar year
  - The Evidence of Coverage covers a complete routine eye exam with dilation as needed. The exam is used to check all aspects of your vision.
- **Eyeglass Lenses** - covered once per calendar year
  - Standard plastic (CR39) eyeglass lenses up to 55mm are covered, whether they're single vision, bifocal, trifocal (FT 25-28) or progressive.
  - There are a number of additional covered lens options that are available through Blue View Vision providers.
- **Frames** - covered once per calendar year
  - Blue View Vision providers will have a collection of frames for you to choose from. They can tell you which frames are included at no extra charge — and which ones will cost you more.
- **Contact Lenses** - each year, you get a lens benefit for eyeglass lenses, non-elective contact lenses or elective contact lenses. But, you can only get one of those three options in a given year. Blue View Vision providers will have a collection of contact lenses for you to choose from.
  - Elective contact lenses are ones you choose for comfort or appearance.
  - Non-elective contact lenses are ones prescribed for certain eye conditions:
    - Keratoconus where the patient is not correctable to 20/40 in either or both eyes using standard spectacle lenses
    - High ametropia exceeding -12D or +9D in spherical equivalent
    - Anisometropia of 3D or more
    - For patients whose vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.
- **Low Vision** is when you have a significant loss of vision, but not total blindness. Your plan covers services for this condition when you go to a Blue View Vision eye care provider who specializes in low vision. They include a comprehensive low vision exam (instead of a routine eye exam), optical/non optical aids or supplemental testing.

Limitations- Blue View Vision

- **Routine Eye Exam** - covered once per calendar year per member
- **Standard Plastic Lenses** - one set of lenses covered per calendar year per member.
- **Frames** - one frame covered per calendar year per member.
- **Contact Lenses** - Elective or non-elective contact lenses are covered once per calendar year per member.
- **Low Vision** - Low vision benefits are only available when received from Blue View Vision Providers.
- **Comprehensive Low Vision Exam** - covered once per calendar year per member.
- **Optical/non-optical aids and supplemental testing** - limited to one occurrence of either optical/non-optical aids or supplemental testing per calendar year per member.

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 reversal of an elective sterilization
- 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 or prescription drugs that are 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-skilled care in sub-acute settings or custodial care
- Nutritional and dietary supplements, except as described in the Evidence of Coverage
- Over-the-counter drugs, devices or products, except as described in the Evidence of Coverage
- Routine foot care, corrective shoes and shoe inserts, except as described in the Evidence of Coverage
- 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
- 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

Your prescription drug benefits do not cover:

- Administration charges, except as described in the Evidence of Coverage
- Allergenic extracts or vaccines
- Compound drugs
- Contrary to approved medical and professional standards
- Delivery charges
- Drugs given at the provider's office / facility
- Drugs not approved by the FDA
- Drugs over quantity or age limits
- Drugs over the quantity prescribed or refills after one year
- Drugs prescribed by providers lacking qualifications / certifications
- Drugs that do not need a prescription
- Drugs used for cosmetic purposes
- Drugs used to treat infertility
- Gene therapy
- Items covered as durable medical equipment (DME)
- Lost or stolen drugs
- Mail service programs other than HealthKeepers' Home Delivery Mail Service
- Off label use, unless required by law
- Over the counter drugs, devices or products
- Sexual dysfunction drugs
- Weight loss drugs

Exclusions – Embedded pediatric dental benefits

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 unless 60 months has passed since initial placement and the existing partial denture cannot be repaired or adjusted.
- 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 Family Value, Anthem Dental Family and Anthem Dental Family Enhanced Benefits for members to the age of 19

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 unless the member's medical records include documentation of medical necessity.
- 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 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 unless 60 months has passed since initial placement and the existing partial denture cannot be repaired or adjusted.
- 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).

Exclusions – Embedded pediatric vision benefits

- Vision care for members age 19 and older, unless covered by the medical benefits of the Evidence of Coverage.
- For any condition, disease, defect, ailment or injury arising out of and in the course of employment if benefits are available under the Workers' Compensation Act or any similar law. This exclusion applies if a member receives the benefits in whole or in part. This exclusion also applies whether or not the member claims the benefits or compensation. It also applies whether or not the member recovers from any third party.
- To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- For which the member has no legal obligation to pay in the absence of this or like coverage.
- For services or supplies prescribed, ordered or referred by, or received from a member of the member's immediate family, including the member's spouse or domestic partner, child, brother, sister or parent.
- For completion of claim forms or charges for medical records or reports.
- For missed or cancelled appointments.
- For safety glasses and accompanying frames.
- Visual therapy, such as orthoptics or vision training and any associated supplemental testing.
- For two pairs of glasses in lieu of bifocals.
- For plano lenses (lenses that have no refractive power).
- For medical or surgical treatment of the eyes, including inpatient or outpatient hospital vision care, except as specified in the "What is Covered" section of the Evidence of Coverage.
- Lost or broken lenses or frames, unless the member has reached their normal interval for service when seeking replacements.
- For services or supplies not specifically listed in the Evidence of Coverage.
- Cosmetic lenses or options, such as special lens coatings or non-prescription lenses, unless specifically listed in the Evidence of Coverage.
- For services or supplies combined with any other offer, coupon or in-store advertisement, or for certain brands of frames where the manufacturer does not allow discounts.
- No benefits are available for frames or contact lenses purchased outside of our formulary.
- Services and materials not meeting accepted standards of optometric practice or services that are not performed by a licensed provider.
- Blended lenses.
- Oversize lenses.
- For sunglasses.

Exclusions - Blue View Vision

- Services not listed in the "Your Vision Benefits" section of the Evidence of Coverage.
- Sunglasses. Sunglass lenses or accompanying frames.
- Any amounts in excess of the maximum benefits stated in the Evidence of Coverage.
- Premium contact lenses fittings.
- Cosmetic lens options not specifically listed in the "What is Covered" section of the Evidence of Coverage.
- Any non-prescription lenses, eyeglasses or contacts, or plano lenses or lenses that have no refractive power.
- Any diagnostic testing or medical or surgical treatment of the eyes, including any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye, such as nearsightedness (myopia) and/or astigmatism. We also will not cover any contact lenses or eyeglasses required as a result of this surgery.
- Any lost or broken lenses or frames, unless you have reached a new benefit period.
- Services received before your effective date or after your coverage ends.
- Services for which you are not legally obligated to pay, for which you are not charged, or for which no charge is made in the absence of insurance coverage.
- Any condition for which benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation law or similar law, even if you do not claim those benefits. If there is a dispute or substantial uncertainty as to whether benefits may be recovered for those condition pursuant to any workers' compensation law or similar law, we will provide the benefits of this plan for such condition, subject to our right to a lien or other recovery applicable law.
- Any services actually given to you by a local, state, or federal government agency, or by a public school system or school district, except when payment under this plan is expressly required by federal or state law. We will not cover payment for these services if you are not required to pay for them or they are given to you for free.
- Treatment or services rendered by non-licensed providers and treatment or services for which the provider of services is not required to be licensed.
- Services of relatives.
- Orthoptics or vision training and any associated supplemental testing.
- Missed or cancelled appointments.
- Services or supplies combined with any other offer, coupon or in-store advertisement.

This piece is only one part of your information kit. This piece refers to the Evidence of Coverage form # VA_HMPSHS_(1/17). Schedule of benefits forms: VA_SB_CAT_HMO_7150_0_40_(1/17), VA_SB_BRZ_HMO_HSA_6200_25_(1/17), VA_SB_BRZ_HMO_5900_35_40_(1/17), VA_SB_BRZ_HMO_5150_35_45_(1/17), VA_SB_BRZ_HMO_POS_4500_30_35_(1/17), VA_SB_BRZ_HMO_HSA_4900_35_(1/17), VA_SB_SVR_HMO_3500_15_45_(1/17), VA_SB_SVR_HMO_2800_20_35_(1/17), VA_SB_SVR_HMO_POS_2300_20_20_(1/17), VA_SB_SVR_HMO_1800_30_35_(1/17), VA_SB_GLD_HMO_1000_20_35_(1/17), VA_SB_BRZ_HMO_POS_HSA_5750_0_(1/17), VA_SB_GLD_HMO_1300_20_20_(1/17), VA_SB_BRZ_HMO_6350_40_(1/17), VA_SB_SVR_HMO_5000_25_30_(1/17). This piece refers to dental policy form #'s: 11-10141.46 13-03281.46 IND 0117.

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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.

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1-800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
If you need assistance to understand this document in an alternate language, you may request it at no additional cost by calling the Member Services number (855-330-1108). (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the Member Services telephone number on the back of your ID card.

Spanish
Si necesita ayuda para entender este documento en otro idioma, puede solicitarla sin costo adicional llamando al número de Servicios para Miembros (855-330-1108). (TTY/TDD: 711)

Amharic
ይህንን ሰነድ ለመረዳት በአማራጭ ቋንቋ እርዳታ ማግኘት ከፈለጉ፣ የአባል አገልግለቶች ቁጥርን (855-330-1108) **በመደወል ያለምንም ክፍያ ማግኘት ይችላሉ።** (TTY/TDD: 711)

Arabic
إذا احتجت إلى المساعدة لفهم هذا المستند بلغة أخرى، فيمكنك طلب المساعدة دون تكلفة إضافية من خلال الاتصال برقم خدمات الأعضاء (855-330-1108). (TTY/TDD: 711)

Bassa
Ɔ jŭ ké m̀ dyi gbo-kpá-kpá mó ɓɛ́ m̀ ké céè-dɛ̀ nìà kɛ múin wó dɛ́ bãà-wɛ̃̂n wùdù dò mú nĭ, m̀ ɓɛ̂n ɔ zɔ̀ɔ̀ dyìin dɛ́ Mɛ́ɓà jè gbo-gmɔ̀ Kpòɛ̀ nɔ̀ɓà nìà kɛ <855-330-1108> dá dá mú. M̀ se wĭdĭ kàkò dò pɛ̂n mu. (TTY/TDD: 711)

Bengali
একটি বিকল্প ভাষায় এই তথ্য পুস্কাটি বো·ঝার জন্য। যদি আপনার সহায়তার প্রয়ো·জন হয়, তাহলে কো·নো·া অতিরিক্ত খরচ ছাড়া সদস্য পরিষেবা নম্বর (855-330-1108)-তে কল করে আপনি এটির অনুরো·ধ করতে পারেন। (TTY/TDD: 711)

Chinese
如果您需要協助以便以另一種語言理解本文件，您可以撥打成員服務號碼(855-330-1108)請求免費協助。(TTY/TDD: 711)

Farsi
در صورتی که برای درک این سند به زبانی دیگر نیازمند کمک هستید،
می‌توانید بدون هیچ هزینه اضافی این را درخواست کنید. برای این کار با
مرکز خدمات اعضاء به شماره 855-330-1108 تماس بگیرید، (TTY/TDD: 711)

French
Si vous avez besoin d'aide pour comprendre ce document dans une autre langue, vous pouvez en faire la demande gratuitement en appelant les Services destinés aux membres au numéro suivant : 855-330-1108. (TTY/TDD: 711)

German
Falls Sie Hilfe in einer anderen Sprache benötigen, um dieses Dokument zu verstehen, können Sie diese kostenlos anfordern, indem Sie die Servicenummer für Mitglieder anrufen (855-330-1108). (TTY/TDD: 711)

Hindi
अगर आपको यह दस्तावेज़ वैकल्पिक भाषा में समझने के लिए सहायता की ज़रूरत है, तो आप सदस्य सेवाएँ नंबर (855-330-1108) पर कॉल करके अतिरिक्त लागत के बिना इसके लिए अनुरोध कर सकते हैं। (TTY/TDD: 711)

Igbo
Ọ bụrụ na ị chọrọ enyemaka iji ghọta dọkụmentị a n'asụsụ dị iche, ị nwere ike ịrịọ ya na akwụghị ụgwọ ọ bụla ọzọ site na ịkpọ nọmba Ọrụ Onye Otu (855-330-1108). (TTY/TDD: 711)

Korean
다른 언어로 본 문서를 이해하기 위해 도움이 필요하실 경우, 추가 비용 없이 회원 서비스 번호(855-330-1108)로 전화를 걸어 도움을 요청할 수 있습니다. (TTY/TDD: 711)

Russian
Если вам нужна помощь, чтобы понять содержание настоящего документа на другом языке, вы можете бесплатно запросить ее, позвонив в отдел обслуживания участников (855-330-1108). (TTY/TDD: 711)

Tagalog
Kung kailangan ninyo ng tulong upang maunawaan ang dokumentong ito sa ibang wika, maaari ninyo itong hilingin nang walang karagdagang bayad sa pamamagitan ng pagtawag sa Member Services sa numerong (855-330-1108). (TTY/TDD: 711)

Urdu
تو آپ ممبر سروس نمبر پر کال اگر اپ کو کسی دوسری زبان میں اس دستاویز کو سمجھنے کے لیے مدد کی ضرورت ہوجس کے لئے آپ پر کوئی اضافی اخراجات عائد نہیں ہوں گے نمبرکرکے اس کی درخواست کرسکتے ہیں
(855-330-1108) (TTY/TDD:711)

Vietnamese
Nếu quý vị cần hỗ trợ để hiểu được tài liệu này bằng một ngôn ngữ thay thế, quý vị có thể yêu cầu mà không tốn thêm chi phí bằng cách gọi số của Dịch Vụ Thành Viên (855-330-1108). (TTY/TDD: 711)

Yoruba
Tí o bá nílò ìránwọ́ kí àkọsílẹ̀ yìí le yé ọ ní èdè míràn, o le bèrè rẹ̀ láìsí àfikún owó nípa pípe Nọ́mbà Àwọn ìpèsè ọmọ-ẹgbẹ́ (855-330-1108). (TTY/TDD: 711)

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