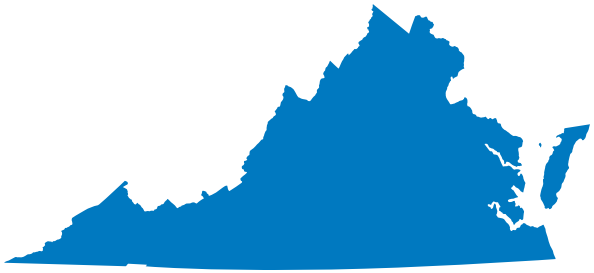
Open enrollment period runs
November 1, 2018 - December 15, 2018

Anthem
And Its Affiliate HealthKeepers, Inc.

How to choose and use your health plan

Get the answers you need with this helpful guide



Virginia

2019 Plan Year

Individual and Family

Bronze, Silver, Gold and Catastrophic plans

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What you need to know to choose a plan that's right for you.

Your options for coverage

Medical plans: Our individual and family health plans give you a variety of options. You'll get for preventive care, such as screenings and flu shots, for as low as $0, with no copay from **in-network** doctors (doctors in your plan). Plus, you won't have to meet your deductible first. And you'll have the health coverage you need in case of an emergency or illness. These are HMO medical plans that don't offer out-of-network benefits, except for emergency and urgent care or when service is preapproved. If you see a doctor not in the plan for any other reason, you'll have to pay 100% out-of-pocket.

Dental/vision: With many of our health plans, you'll get federally required pediatric health benefits for dental and vision. For extra coverage, Anthem Blue Cross and Blue Shield offers stand-alone dental with buy-up vision insurance for you and your whole family.

Term Life insurance: Anthem Life Insurance Company now offers term life insurance coverage. Our Individual term life plans include two coverage options: $25,000 and $50,000. You can choose the coverage amount that fits your needs. Life insurance is an important decision, but it doesn't have to be a complicated one. Term Life Insurance underwritten by Anthem Life Insurance Company.

Pharmacy: Pharmacy is the most widely used benefit—4X more than medical—and often the first benefit members access.[1] Getting the most out of your pharmacy benefits can help keep you healthy and save you money.

- **Your covered medications:** To see if your drug is covered, go to anthem.com/pharmacyinformation and choose the link, **Virginia Select Drug List (Searchable)** or **(PDF)**.
- **Retail Pharmacies:** Your pharmacy benefit includes nearly 70,000 retail pharmacies nationwide. To see if your preferred pharmacy is in the plan's network, visit anthem.com/pharmacyinformation/rxnetworks.html.
- **Home Delivery:** Get your medicine delivered right to your door. People who use home delivery pharmacy are more likely to follow their drug treatment plan and have better health outcomes.

To learn more, call your sales representative.

To learn more, call your sales representative. You can also view and compare plans online at **anthem.com**.

If you'd like a paper copy of this information by fax or mail, call your sales representative.

Our retail and home delivery networks are owned and operated by our pharmacy benefit manager, Express Scripts.

1 Retail Prescription Drugs Filled at Pharmacies (Annual per Capita) (accessed 2/16/2017): kff.org; Ambulatory Care Use and Physician office visits, US Centers for Disease Control and Prevention (accessed 2/16/2017), https://www.cdc.gov/nchs/fastats/physician-visits.htm; https://www.cdc.gov/nchs/fastats/drug-use-therapeutic.htm; and http://www.statista.com/chart/2689/americans-dont-like-visiting-the-doctor (accessed June 17, 2015).

Answers to your questions

Why choose HealthKeepers?

When you choose an individual or family plan with HealthKeepers, you get access to doctors, hospitals and specialists from our recognized network across Virginia. It's important to us that you have convenient access to care you can depend on.

You'll see the difference with HealthKeepers. You can select doctors, care centers and hospitals from our network of providers. You can also have a private video visit with a doctor or therapist on your smartphone, tablet or computer. It's one of the best ways for us to help support your health and the health of your family.

Access to preventive care

At HealthKeepers, we believe that prevention is the best medicine. Preventive care is offered for as low as $0 with no copay and no deductible to meet when received from doctors in your plan.

With us, you can also count on:

- Dedicated customer service.
- A simple enrollment process.
- Resources to support your health care goals.

Why do I need coverage?

The short answer is ... life happens and it helps to be ready. No one plans to break an arm or catch pneumonia. That's why having a health care plan is so important. It helps you:

- Pay for those unexpected costs that come with a serious illness or injury.
- Get some important benefits like preventive care that can help you stay healthier and get more effective treatment.

Still not convinced? Here are three reasons why coverage is so important:

1. **It's worth the price.** Have you ever thought about what the cost would be to have a major surgery without health insurance? Now picture adding that in with your mortgage/rent and monthly expenses. That's a case where monthly payments for coverage are small compared to footing the bill for a major unexpected cost.
2. **It helps you stay on top of checkups.** When you have coverage, you'll be much more likely to use it to get your yearly checkups and tests that can catch issues early.
3. **It's an investment in you.** You insure your home and cars, so why would you put yourself at the bottom of the list? Think about how much it would cost to fix you if something serious were to happen.

Answers to your questions

What coverage do I need?

Choosing the right plan for you can be a challenge. We get that. So let's start with some questions to figure out what works best for 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?
- **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, lower monthly payment, Catastrophic plan. Catastrophic plans can help protect you from worst-case scenarios like serious accidents or illnesses.

Plan choices

Metal Levels

- **Bronze:** You'll have lower monthly payments while being covered for check ups and preventive care. You could pay more out of pocket if you need more care, but if you don't expect to go to the doctor very much this year, Bronze may be a good bet. These health plans can be great for people who are younger with no dependents.
- **Silver:** You'll get health coverage that covers all the basics and more.Silver plans on the Health Insurance Marketplace offer the greatest assistance for both tax credits and cost sharing subsidies if you qualify.
- **Gold:** You'll have higher monthly payments but lower out of pocket costs depending on the services you use. You'll also have a lower deductible to meet, and you can save on visits to doctors or specialists when you need them.

NEW! Enhanced Virtual Access Plans
Online Plus:

- Our Anthem HealthKeepers Bronze X 5700 Online Plus plan offers unlimited, $10 online PCP office visit copays.

Can I afford it?

If you're thinking coverage might cost too much, you're not alone. But, what you might not know is that you may be able to get help paying for it. And a health insurance subsidy may be the answer. Don't know what a subsidy is? That's just a fancy word for getting financial help from the government to help you pay for your health care coverage.

You could be eligible for a subsidy, also called an advanced premium tax credit, to lower your monthly payment. You may also qualify for a plan where you'll pay less for your out-of-pocket costs. You can visit healthcare.gov if you need more information.

Other ways to help save money:

Check if your favorite doctor, hospital or other health care provider is in your plan. That way you can make sure you get your care at the lower or negotiated network rate.

You can also save money by only using the emergency room (ER) for emergencies. Head straight to the ER or call 911 for serious health issues. Otherwise, save yourself money and time by visiting your primary care doctor, an urgent care center, or LiveHealth Online for minor medical issues.

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.

With a qualified high-deductible plan, you can set up the HSA through a bank and fund it with your post tax dollars. Before selecting an HSA plan, check with your tax advisor to see if an HSA plan is right for you.

Answers to your questions

How do I find a doctor or hospital?

You can find an in-network doctor, hospital, dentist, pharmacy and more by using our **Find a Doctor tool**. It's quick and easy. Plus, you'll get the most from your health care coverage, if you choose a doctor or hospital in your plan. Follow these simple steps:

1. Go to **anthem.com**.
2. Choose **Individual & Family** at the top of your screen. Then under **Care** select **Find a Doctor**.
3. Scroll past Search as a Member to **Search as Guest**.
4. Choose **Search by Selecting a Plan or Network** and complete the form.

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 not contracted with the health plan may cost more.

What should I know about my network?

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 don't have to pick one.

Our plans are only available in the following counties and cities: ***Accomack, Albemarle, Alleghany, Amherst, Appomattox, Augusta, Bath, Bedford, Bedford City, Bland, Botetourt, Bristol City, Brunswick, Buchanan, Buckingham, Buena Vista City, Campbell, Caroline, Carroll, Charlotte, Charlottesville City, Chesapeake City, Covington City, Craig, Culpeper, Cumberland, Danville City, Dickenson, Emporia City, Essex, Fauquier, Floyd, Fluvanna, Franklin, Franklin City, Frederick, Fredericksburg City, Galax City, Giles, Gloucester, Goochland, Grayson, Greene, Greensville, Halifax, Hampton City, Harrisonburg City, Henry, Highland, Isle of Wight, James City, King and Queen, King George, King William, Lancaster, Lexington City, Lee, Louisa, Lunenburg, Lynchburg City, Madison, Martinsville City, Mathews, Mecklenburg, Middlesex, Montgomery, Nelson, New Kent, Newport News City, Norfolk City, Northampton, Northumberland, Norton City, Nottoway, Orange, Page, Patrick, Pittsylvania, Poquoson City, Portsmouth City, Powhatan, Prince Edward, Pulaski, Radford City, Rappahannock, Richmond, Roanoke, Roanoke City, Rockbridge, Rockingham, Russell, Salem City, Scott, Shenandoah, Smyth, Southampton, Spotsylvania, Staunton City, Suffolk City, Surry, Tazewell, Virginia Beach City, Washington, Waynesboro City, Westmoreland, Williamsburg City, Winchester City, Wise, Wythe, York***.

- **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 see a doctor not in the plan for any other reason, you'll have to pay 100% out of pocket.

- **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 amount 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**.

Member advantages

Making informed health care decisions for you and your family is simple with our website, mobile app and helpful tools, like Estimate Your Cost.

No matter which plan you choose, you can register at anthem.com or on the Anthem Anywhere mobile app to get personalized information about your health plan.

Use the self-service tools on our secure website to:

- See your claims and coverage details.
- Estimate your costs on common procedures, before you step into the doctor's office.
- Manage your prescription benefits and search the drug list that applies to your plan.
- Check the price of a drug or refill a prescription.
- Make your monthly payments online.

With our Anthem Anywhere mobile app, you can:

- Find a nearby doctor, specialist, urgent care center or hospital.
- Download a virtual member ID card.
- Manage your prescription drug benefits.

LiveHealth® ONLINE

You can also take advantage of resources like LiveHealth Online:

Talk to a doctor whenever, wherever with LiveHealth Online	LiveHealth Online Psychology offers virtual counseling
Easy: Connect to a doctor 24 hours a day, from a computer, tablet, or smartphone. **Face-to-face**: Chat by two-way video for common health issues. **Save:** On average members save up to $201 for care, compared to ER, urgent care, or other health facilities.*	**Convenient:** Sessions go from 7 a.m. to 11 p.m., coast-to-coast. **Quick access:** Schedule a visit and be seen within four days, or on demand. **Similar cost:** Cost-share is the same as it is for in-office Mental Health/Substance Use therapy benefits.

*Results based on internal LiveHealth Online study during 2014 and first quarter, 2015.

Member advantages

Plans include other features to help you and your family stay healthy at no additional cost.

- **24/7 Nurseline:** Our registered nurses can answer your health questions wherever you are – any time, day or night. All you have to do is call.
- **Care Support:** If you need extra care for ongoing or complex health issues, a case manager may call you. Your case manager can answer your questions, set up care with different doctors and help you use your health benefits.
- **MyHealth Advantage:** Avoid health issues, stay healthy and save money. This program tracks your health information to see if there's anything you can do to improve your health. If so, you'll get a personalized and confidential MyHealth Note in the mail.

Peace of mind when you travel.

Travel a lot? Don't worry. You're covered.

Whether you're traveling for work or on vacation, going to the ER or urgent care is the last thing you want to worry about. The good news is you don't have to! All of our plans cover medically necessary emergency and urgent care in all 50 states, even when you're not using your plan's doctors and hospitals.

Simplified payments

We know life gets busy, so we're making it easier for you to pay your monthly payments.

- Set up electronic funds transfer (EFT) or bank draft.
- Enroll in WebPay to use with a Visa or MasterCard debit or credit card.
- Download our Anthem Anywhere app and pay with a credit card or your bank account. You can even set up autopay in the app.

You can set up automatic monthly payments with each option. Just make sure your card account information and expiration date stays up to date.

Plan benefit chart - 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 services approved in advance by HealthKeepers.
All medical plans include embedded pediatric dental and vision benefits. For more details, see page 13-14.

	Anthem HealthKeepers Bronze 4900 for HSA (3749)	**Anthem HealthKeepers Bronze 5250 (374C)**	**Anthem HealthKeepers Bronze 5700 Online Plus (375N) *NEW***
Network name	Pathway X Tiered Hospital	Pathway X Tiered Hospital	Pathway X Tiered Hospital
Plan includes out-of-network coverage?	No	No	No
Individual deductible[1]	$4,900	$5,250	$5,700
Individual out-of-pocket limit	$6,700	$7,900	$7,900
Coinsurance (percentage may vary for some covered services)	35%	35%	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 35% coinsurance	$40 copay	$35 copay
Office visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 35% coinsurance	Deductible, then 35% coinsurance	Deductible, then 30% coinsurance
Outpatient diagnostic tests[4] (Ex. X-ray, EKG)	Tier 1: Deductible, then 35% coinsurance Tier 2: Deductible, then 50% coinsurance	Tier 1: Deductible, then 35% coinsurance Tier 2: Deductible, then 50% coinsurance	Tier 1: Deductible, then 30% coinsurance Tier 2: Deductible, then 50% coinsurance
Outpatient advanced diagnostic tests[4] (Ex. MRI, CT scan)	Deductible, then 50% coinsurance	Deductible, then 50% coinsurance	Deductible, then 50% coinsurance
Urgent care	Deductible, then 35% coinsurance	Deductible, then 35% coinsurance	Deductible, then 30% coinsurance
Emergency room care	Deductible, then 50% coinsurance	Deductible, then 50% coinsurance	Deductible, then 50% coinsurance
Hospital: inpatient admission[4] (includes maternity, mental health / substance use)	Tier 1: Deductible, then 35% coinsurance Tier 2: Deductible, then 50% coinsurance	Tier 1: Deductible, then 35% coinsurance Tier 2: Deductible, then 50% coinsurance	Tier 1: Deductible, then 30% coinsurance Tier 2: Deductible, then 50% coinsurance
Hospital: outpatient surgery hospital facility[4] (includes maternity)	Tier 1: Deductible, then 35% coinsurance Tier 2: Deductible, then 50% coinsurance	Tier 1: Deductible, then 35% coinsurance Tier 2: Deductible, then 50% coinsurance	Tier 1: Deductible, then 30% coinsurance Tier 2: Deductible, then 50% coinsurance
Pharmacy deductible (for tiers with deductible, cost share applies after deductible)	Tiers 1, 2, 3, 4: Medical deductible applies	Tiers 1, 2, 3, 4: Medical deductible applies	Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies
Retail pharmacy tier 1	35% coinsurance	35% coinsurance	$25
Retail pharmacy tier 2	35% coinsurance	50% coinsurance	$60
Retail pharmacy tier 3	50% coinsurance	50% coinsurance	50% coinsurance
Retail pharmacy tier 4	50% coinsurance	50% coinsurance	50% coinsurance
Mental health / substance use: outpatient facility & services[4]	Deductible, then 35% coinsurance	Deductible, then 35% coinsurance	Deductible, then 30% coinsurance

Please see Medical plans footnotes on page 12.

Plan benefit chart - 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 services approved in advance by HealthKeepers.
All medical plans include embedded pediatric dental and vision benefits. For more details, see page 13-14.

	Anthem HealthKeepers Bronze 5900 (374F)	**Anthem HealthKeepers Bronze 6500 (374J)**	**Anthem HealthKeepers Silver 1800 (375A)**
Network name	Pathway X Tiered Hospital	Pathway X Tiered Hospital	Pathway X Tiered Hospital
Plan includes out-of-network coverage?	No	No	No
Individual deductible[1]	$5,900	$6,500	$1,800
Individual out-of-pocket limit	$7,900	$7,900	$7,900
Coinsurance (percentage may vary for some covered services)	35%	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)	$35 copay per visit for the first 5 visits, then deductible and 35% coinsurance	Deductible, then 40% coinsurance	$35 copay
Office visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 35% coinsurance	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance
Outpatient diagnostic tests[4] (Ex. X-ray, EKG)	Tier 1: Deductible, then 35% coinsurance Tier 2: Deductible, then 50% coinsurance	Tier 1: Deductible, then 40% coinsurance Tier 2: Deductible, then 50% coinsurance	Tier 1: Deductible, then 30% coinsurance Tier 2: Deductible, then 50% coinsurance
Outpatient advanced diagnostic tests[4] (Ex. MRI, CT scan)	Deductible, then 50% coinsurance	Deductible, then 50% coinsurance	Deductible, then 50% coinsurance
Urgent care	Deductible, then 35% coinsurance	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance
Emergency room care	Deductible, then 50% coinsurance	Deductible, then 50% coinsurance	Deductible, then 50% coinsurance
Hospital: inpatient admission[4] (includes maternity, mental health / substance use)	Tier 1: Deductible, then 35% coinsurance Tier 2: Deductible, then 50% coinsurance	Tier 1: Deductible, then 40% coinsurance Tier 2: Deductible, then 50% coinsurance	Tier 1: Deductible, then 30% coinsurance Tier 2: Deductible, then 50% coinsurance
Hospital: outpatient surgery hospital facility[4] (includes maternity)	Tier 1: Deductible, then 35% coinsurance Tier 2: Deductible, then 50% coinsurance	Tier 1: Deductible, then 40% coinsurance Tier 2: Deductible, then 50% coinsurance	Tier 1: Deductible, then 30% coinsurance Tier 2: Deductible, then 50% coinsurance
Pharmacy deductible (for tiers with deductible, cost share applies after deductible)	Tier 1: No deductible Tiers 2, 3, 4: Medical deductible applies	Tiers 1, 2, 3, 4: Medical deductible applies	Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies
Retail pharmacy tier 1	$30	40% coinsurance	$20
Retail pharmacy tier 2	35% coinsurance	40% coinsurance	$50
Retail pharmacy tier 3	50% coinsurance	50% coinsurance	50% coinsurance
Retail pharmacy tier 4	50% coinsurance	50% coinsurance	50% coinsurance
Mental health / substance use: outpatient facility & services[4]	Deductible, then 35% coinsurance	Deductible, then 40% coinsurance	Deductible, then 30% coinsurance

Please see Medical plans footnotes on page 12.

Plan benefit chart - 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 services approved in advance by HealthKeepers.
All medical plans include embedded pediatric dental and vision benefits. For more details, see page 13-14.

	Anthem HealthKeepers Silver 6100 (375G)	**Anthem HealthKeepers Gold 1350 (374P)**	**Anthem HealthKeepers Catastrophic 7900 (374M)**
Network name	Pathway X Tiered Hospital	Pathway X Tiered Hospital	Pathway X Tiered Hospital
Plan includes out-of-network coverage?	No	No	No
Individual deductible[1]	$6,100	$1,350	$7,900
Individual out-of-pocket limit	$7,900	$7,900	$7,900
Coinsurance (percentage may vary for some covered services)	35%	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	$25 copay	$40 copay per visit for the first 3 visits, then deductible and 0% coinsurance
Office visit: specialist (Other office services may be subject to deductible and plan coinsurance)	Deductible, then 35% coinsurance	Deductible, then 20% coinsurance	Deductible, then 0% coinsurance
Outpatient diagnostic tests[4] (Ex. X-ray, EKG)	Tier 1: Deductible, then 35% coinsurance Tier 2: Deductible, then 50% coinsurance	Tier 1: Deductible, then 20% coinsurance Tier 2: Deductible, then 50% coinsurance	Deductible, then 0% coinsurance
Outpatient advanced diagnostic tests[4] (Ex. MRI, CT scan)	Deductible, then 50% coinsurance	Deductible, then 50% coinsurance	Deductible, then 0% coinsurance
Urgent care	Deductible, then 35% coinsurance	Deductible, then 20% coinsurance	Deductible, then 0% coinsurance
Emergency room care	Deductible, then 50% coinsurance	Deductible, then 40% coinsurance	Deductible, then 0% coinsurance
Hospital: inpatient admission[4] (includes maternity, mental health / substance use)	Tier 1: Deductible, then 35% coinsurance Tier 2: Deductible, then 50% coinsurance	Tier 1: Deductible, then 20% coinsurance Tier 2: Deductible, then 50% coinsurance	Deductible, then 0% coinsurance
Hospital: outpatient surgery hospital facility[4] (includes maternity)	Tier 1: Deductible, then 35% coinsurance Tier 2: Deductible, then 50% coinsurance	Tier 1: Deductible, then 20% coinsurance Tier 2: Deductible, then 50% coinsurance	Deductible, then 0% coinsurance
Pharmacy deductible (for tiers with deductible, cost share applies after deductible)	Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies	Tiers 1, 2: No deductible Tiers 3, 4: Medical deductible applies	Tiers 1, 2, 3, 4: Medical deductible applies
Retail pharmacy tier 1	$15	$10	0% coinsurance
Retail pharmacy tier 2	$60	$40	0% coinsurance
Retail pharmacy tier 3	50% coinsurance	50% coinsurance	0% coinsurance
Retail pharmacy tier 4	50% coinsurance	50% coinsurance	0% coinsurance
Mental health / substance use: outpatient facility & services[4]	Deductible, then 35% coinsurance	Deductible, then 20% coinsurance	Deductible, then 0% coinsurance

Please see Medical plans footnotes on page 12.

Medical plans benefit footnotes

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 the Gold plan.

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 PCP web visits, including **LiveHealth Online**, have the same PCP office visit cost share listed in the chart, except for Online Plus plans. Available on the Anthem HealthKeepers Bronze X 5700 Online Plus plan, Online Plus offers unlimited, $10 online PCP office visit copays.

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 medically 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	***in-network***
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% coinsurance	0% coinsurance
Basic services	*No waiting period*	*No waiting period*
Fillings	40% coinsurance	0% coinsurance
Complex and major services	*No waiting period*	*No waiting period*
Endodontic/periodontic/oral surgery	50% coinsurance	0% coinsurance
Major services	50% coinsurance	0% coinsurance
Dentally necessary orthodontia[2]	50% coinsurance	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 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.

	Benefit frequency	Cost share *in-network*
Eye exam	Once every benefit period	$0 copay up to maximum allowed amount
Lenses (single, biofocal, trifocal and standard progressive)	Once every benefit period	$0 copay up to maximum allowed amount
Frames	Once every benefit period	Anthem formulary[1]
Contact lenses (Non-elective)	Once every benefit period[2]	Covered in full
Contact lenses (Elective/disposable)	Once every benefit period[2]	Anthem formulary[1]
Low vision services (loupes and magnifiers)	Once every benefit period	$0 copay (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.

Understanding insurance terms

Let’s take a look at some common insurance terms you probably see a lot.

Here’s what they mean:

Coinsurance: Your percentage of the costs. After you meet your deductible, this is your percentage of costs each time you get care and then your plan covers the rest up to the maximum allowed amount. In-network providers agree to accept HealthKeepers' maximum allowed amount as their charge.

Copay: This is a set dollar amount you pay for covered services, such as doctor visits. The amount can vary based on covered service. It’s listed in your medical plan charts.

Deductible: This is the set dollar amount you pay before we begin paying for most covered health services you receive. It’s listed in your benefit plan. **In-network** covered preventive services don’t require a deductible. Your deductible applies to the calendar year (January 1 through December 31), even if your effective date (the date coverage begins) is later than January 1.

Drug tiers: Drugs on a drug list or formulary are typically arranged in tiers. Your cost depends on which drug tier your drug is in.

In-network coverage: This refers to doctors, hospitals, dentists, pharmacies and other care providers who are part of the plan’s network or are in the plan. In-network providers agree to accept HealthKeepers' maximum allowed amount as their charge. HMO plans only include coverage for in-network benefits, except for emergency and urgent care, ambulance services, or when a service is pre-approved.

Out-of-network coverage: This refers to doctors, hospitals, dentists, pharmacies and other care providers who don’t participate in the plan or network. HMO plans don’t offer out-of-network benefits, except for emergency and urgent care, ambulance services, or when a service is pre-approved.

Out-of-pocket limit: This is the maximum amount you can pay out of your pocket for covered services each year. Once you reach that limit, which varies by plan, we cover the rest up to the maximum allowed amount. In-network providers agree to accept HealthKeepers' maximum allowed amount as their charge.

Plan name: Plan name and contract code are found on 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.

Ready to enroll? Let's get started.

Help is close at hand:

Call your sales representative. to enroll or learn more about our health care plans. Take a look at the **application** included with this brochure.

Visit our website at anthem.com and apply online.

You can buy health care plans once a year through an open enrollment period. This year, the open enrollment period runs from **November 1, 2018 - December 15, 2018**. Be sure to enroll by December 15, 2018, to start coverage effective January 1, 2019.

You may be able to change your health coverage outside of this open enrollment period if there are special qualifying events. Check with your HealthKeepers sales representative to see if you qualify or if you have other questions about open enrollment.

We want you to be satisfied

After you enroll in one of our plans, you'll have access to your *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.

Summary of benefits and services

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 **NEXT** for Summaries in English or Spanish. Other languages can also be selected.

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 Affordable Care Act (ACA), the following plan changes may occur annually on January 1:

- Benefits
- Premiums (monthly payments)
- Deductibles, copays, coinsurance and out-of-pocket-limits

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

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 United States citizen or national; or a lawfully present non-citizen and a resident of the Commonwealth 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 also 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 benefit/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.

Reviewing where services are provided

A service must be medically necessary to be a covered service. The utilization review may include a review of the level of care, type of setting or place of service where services can be safely given to you. If services are given in a higher level of care or cost setting when they could be safely given in a lower level place of care or cost setting, they will not be determined to be medically necessary. The service(s), in that case, are being denied based on the review of where they are provided. When this happens the service(s) can be requested again in another setting or place of care and will be reviewed again for medical necessity. At times, a different type of provider or facility may need to be used in order for the service to be considered medically necessary.

Examples include, but are not limited to:

- A service may be denied on an inpatient basis at a hospital but may be approved if provided on an outpatient basis in a Hospital setting.
- A service may be denied on an outpatient basis if taking place in a hospital setting but may be approved at a free-standing imaging center, infusion center, ambulatory surgical center/facility, or in a physician's office.
- A service may be denied at a skilled nursing facility but may be approved in a home setting.

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;

Important legal information

- 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. It is important to understand that HMO plans do not offer out of network coverage, with the exception of emergency care as described in the Evidence of Coverage or urgent care services received at an urgent care center or when a service is preapproved. 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 X Tiered Hospital network. It's a good idea to have a primary care doctor (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 doctors.

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.

The only services covered outside our network are emergency care as described in the Evidence of Coverage and urgent care services received at an urgent care center. In addition, you will have emergency and urgent care coverage through the Blue Cross and Blue Shield Association's BlueCard® program using the Traditional (PAR) network. When you use BlueCard providers in the Traditonal 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 authorized in advance by HealthKeepers for use
- Chiropractic – 30 visits for spinal manipulation per member per calendar year for rehabilitation services and 30 visits for spinal manipulation per member per calendar year for habilitation services
- Home health care – 100 visits per member per calendar year
- Private duty nursing provided in a home care setting – 16 hours per member per calendar year
- Skilled nursing facility – 100 days per stay
- Therapy services:

Important legal information

- Physical/Occupational therapy – 30 combined visits per member per calendar year for rehabilitation services and 30 combined visits per member per calendar year for habilitation services
- Speech therapy – 30 visits per member per calendar year for rehabilitation services and 30 visits per member per calendar 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

- **Pulp cap (direct / indirect)**
- **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.
- **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 and root planing** – 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.
- **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.
- **Labial veneers** – covered 1 per 60 months per tooth. This is considered as an alternate treatment to a full restoration for an endodontically treated tooth.

Prosthodontic services

Important legal information

- **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 24 months 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

- Limited orthodontic treatment;
- Interceptive orthodonitc treatment;
- Comprehensive (Complete) orthodontic treatment;
- Removable appliance therapy;
- Fixed appliance therapy; and
- Complex surgical procedure for orthodontic reason, such as exposing impacted teeth or repositioning of the teeth.

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.

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 for 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.

Important legal information

- **Space maintainers** – covered 1 time per lifetime on eligible dependent children through the age of 16 for extracted primary posterior (back) teeth.
- **Brush miopsy** – 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 services) is covered 2 times per calendar year.
- **Periodontal scaling and 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.

Important legal information

- **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 1 time 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 1 time 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 1 time 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 1 of those 3 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 1 time per calendar year per member
- **Standard plastic lenses** – 1 set of lenses covered per calendar year per member.
- **Frames** – 1frame covered per calendar year per member.
- **Contact lenses** – Elective or non-elective contact lenses are covered 1 time 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 1 time per calendar year per member.
- **Optical/non-optical aids and supplemental testing** – limited to 1 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
- 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

Important legal information

- 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 / registrations / 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
- Services not medically necessary
- 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).

Important legal information

- 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 conscious sedation, analgesia, and general anesthesia not covered when given separate from 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, 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, excepting root canal treatments, which is covered once per tooth, per lifetime.

Exclusions – Dental Prime plans

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

Important legal information

- 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).

Important legal information

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.
- 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_(1/19). Schedule of benefits forms: VA_SB_BRZ_HMO_5250_35_40_(1/19), VA_SB_BRZ_HMO_5900_35_35_(1/19), VA_SB_BRZ_HMO_6500_40_(1/19), VA_SB_BRZ_HMO_HSA_4900_35_(1/19), VA_SB_CAT_HMO_7350_0_40_(1/19), VA_SB_GLD_HMO_1100_20_35_(1/19), VA_SB_SVR_HMO_1800_30_35_(1/19), VA_SB_SVR_HMO_2800_20_35_(1/19), VA_SB_SRV_HMO_3500_15_40_(1/19), VA_SB_SVR_HMO_5500_25_30_(1/19), VA_SB_SVR_HMO_6100_35_35_(1/19). This piece refers to dental policy form #'s: 11-10141.46 13-03281.46 IND 0119.

Important legal information

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 (1-855-330-1108). (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 listed above.

Spanish

Si necesita ayuda para entender este documento en otro idioma, puede solicitarla sin costo adicional llamando al número de Servicios para Miembros (1-855-330-1108). (TTY/TDD: 711)

Amharic

ይህንን ሰነድ ለመረዳት በአማራጭ ቋንቋ እርዳታ ማግኘት ከፈለጉ፣ የአባል አገልግለቶች ቁጥርን (1-855-330-1108) **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 (1-855-330-1108) (TTY/TDD: 711)

Bassa

Ɔ jŭ ké m̀ dyi gbo-kpá-kpá mɔ́ ɓɛ́ m̀ ké céè-dɛ̀ n̄ià kɛ múin wɔ́ dɛ́ bãà-wɛ̃̄in wùdù dɔ̀ mú n̄í, m̀ ɓɛ̃̄in ɔ zɔ̀ɔ dy̰ïin dɛ́ Mɛ́ɓà jè gbo-gmɔ̀ Kpòɛ̀ nɔ̀ɓà n̄ià kɛ <1-855-330-1108> dá dá mú. M̀ se wíd̰i kàkò dɔ̀ pɛ̃̄in mu. (TTY/TDD: 711)

Bengali

একটি বিকল্প ভাষায় এই তথ্য পুস্তিকাটি বোঝার জন্য। যদি আপনার সহায়তার প্রয়োজন হয়, তাহলে কোনো অতিরিক্ত খরচ ছাড়া সদস্য পরিষেবা নম্বর (1-855-330-1108)-তে কল করে আপনি এটির অনুরোধ 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(1-855-330-1108)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 1-855-330-1108 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 : 1-855-330-1108. (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 (1-855-330-1108). (TTY/TDD: 711)

Hindi

अगर आपको यह दस्तावेज़ वैकल्पिक भाषा में समझने के लिए सहायता की ज़रूरत है, तो आप सदस्य सेवाएँ नंबर (1-855-330-1108) 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 (1-855-330-1108). (TTY/TDD: 711)

Korean

다른 언어로 본 문서를 이해하기 위해 도움이 필요하실 경우, 추가 비용 없이 회원 서비스 번호(1-855-330-1108)로 전화를 걸어 도움을 요청할 수 있습니다. (TTY/TDD: 711)

Get help in your language

Russian

Если вам нужна помощь, чтобы понять содержание настоящего документа на другом языке, вы можете бесплатно запросить ее, позвонив в отдел обслуживания участников (1-855-330-1108). (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 (1-855-330-1108). (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
(1-855-330-1108) (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 (1-855-330-1108). (TTY/TDD: 711)

Yoruba

Tí o bá nílò ìrànwọ́ kí àkọsílẹ̀ yìí le yé ọ ní èdè míràn, o le bèrè rẹ̀ láìsí àfikún owó nípa pípe Nọ́mbà Àwọn ìpèsè ọmọ-ẹgbẹ́ (1-855-330-1108). (TTY/TDD: 711)

Anthem
And Its Affiliate HealthKeepers, Inc.

So that's how it all works.

Still have questions? Just ask. We're here to help.

To learn more, call Anthem HealthKeepers or your sales representative. You can also view and compare plans online at anthem.com.

If you'd like a paper copy of this information by fax or mail, call Anthem HealthKeepers or your sales representative.

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