Anthem BlueCross BlueShield

Benefits You Can Count On

Cooperative Educational Services
Lumenos HSA
Effective 7-1-2014

Choosing the right plan is a very personal thing.

Use this book to find one that's

- Right for your lifestyle
- Right for your needs
- Right for your peace of mind

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Your guide to Anthem Blue Cross Blue Shield

Welcome! We're so glad you're taking time to check out all that Anthem Blue Cross Blue Shield has to offer you. Choosing your health care plan (and the benefits that go with it) is an important decision and this booklet is designed to help. Basically, it's a snapshot of the benefits that come with our health plan(s). It shows what's available to you, what you get with each benefit and how the plan(s) work.

Explore the advantages of being an Anthem member.

This booklet goes into all the advantages. But here are the top four:

1. **Our plans can help you stay healthy.** Health plans aren't just something you need when you're sick. We offer easy-to-use plans that are specially designed for people who already have healthy lifestyles. They include things like free preventive care and discounts on over-the-counter products.
2. **You get more than just basic coverage.** You get access to tools, resources and guidance that are customized just for you. Plus we offer online programs to help you get and stay healthy. They'll help you reach your personal goals to be as healthy as possible.
3. **There's so much you can do on our website – after all, it was created just for you.** If you have questions, you'll find the answers you're looking for. Here are some things you can do:
   - Order and print out a temporary member ID card if you lose yours
   - Check the status of a claim
   - Search for a doctor, specialist or hospital
   - Learn about hundreds of health and wellness topics
4. **Finding an in-network doctor, specialist or hospital is a snap.** It's quick and easy to search online. You can make your search specific by choosing a specialty or entering a doctor's name. And if you're away from home, try searching our National Directory.

Once you get your member ID card, all it takes is three simple steps to discover the world of anthem.com.

- Go to anthem.com
- Click on Register
- Create your username and password.

Then you're ready to go!

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Your guide to Anthem Blue Cross Blue Shield (continued)

Join our health conversation.

We've brought together a community of health enthusiasts who share information, tips and inspiration on Facebook, Twitter and YouTube. Follow our pages to get exercise tips from people like you. Get advice on reaching your health and wellness goals. And find things like healthy recipes and exercise how-to videos from our health coaches and trainers.

Connect with us today!

- Facebook.com/HealthJoinIn
- Twitter.com/HealthJoinIn
- YouTube.com/HealthJoinIn

We're teaming up with IBM Watson to help you get the best care.

At times, getting a diagnosis for a complex or rare health issue can be a long, tough process. It's been found that 15-20% of medical errors are caused by a delayed diagnosis.* To help with this issue, we are teaming up with IBM to pioneer a tool using their IBM Watson technology. This tool will help doctors use more complete information about a patient to make a diagnosis. And it will assist them in recommending treatments.

IBM Watson is being developed to access and analyze vast libraries of medical information and millions of health data records. With IBM Watson at their fingertips, we expect that our in-network doctors will be able to make more informed decisions about your health care. And that gets you on the road to your best health quicker.

Visit our website to easily find a doctor or facility.

Scan the code with your mobile capable device for a direct link to anthem.com. Don't have a QR code reader? Download the free ScanLife app to your mobile device or visit scanlife.com.

* Dr. Herb Chase, Columbia University School of Medicine, IBM IBV report, The Future of Connected Healthcare Devices, March 2011.

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Helpful links

anthem.com

While you're there check out the Health and Wellness tab

Facebook.com/HealthJoinIn

While you're there check out the Health Personality Quiz

Twitter.com/HealthJoinIn

YouTube.com/HealthJoinIn

Healthy Footprint

Glossary

Member Online Tools

Your Health Benefits

How your Lumenos® with Health Savings Account (HSA) plan works

Your Lumenos plan helps you take greater control over the money you spend on health care, while helping you get and stay as healthy as possible. Think of it as a health plan and savings account rolled into one. It starts with a savings account that you put tax-deductible money into. This means you don't have to pay income tax on that money. Then, when you need medical care or a prescription, you can take money out of the account to pay for it.

Your Lumenos also comes with many programs and tools that help you take charge of your health, make smart decisions and save money.

The plan works like this:

You put tax-free money into your HSA account. You can use that money to help pay deductibles and other health care costs. Your deductible is a set amount of money that you have to pay before we start paying for medical services and prescriptions that are covered by your plan.

Preventive care is covered 100%

Your plan covers 100% of preventive care when you see a network doctor, so there's nothing taken from your HSA and you won't have to pay out of pocket. To find out more about exams, tests and immunizations you should get, check out the Preventive Care Guidelines at anthem.com.

Once you've met your deductible, we begin paying part of the cost for covered services. You pay the other part, which is called coinsurance. You can use your HSA money to pay your coinsurance, too. There's a limit to how much coinsurance you have to pay before we start paying for the covered services. This limit is called your out-of-pocket maximum.

If this sounds a lot different than any other kind of health plan you've had in the past, don't worry. Getting access to care from doctors and filling prescriptions is just as easy.

Getting started

Step 1: After you join the plan, you'll get your member ID card
Be sure to show the card to your doctors, pharmacy and other health care professionals when you see them.

Step 2: You can go to any doctor, pharmacy or hospital, but staying in network saves you the most money
You can visit any doctor, pharmacy, hospital or other health care provider you want. But there's a difference in the cost and how much you may have to pay.

How your Lumenos® with Health Savings Account (HSA) plan works (Continued)

Getting care

Here's what happens when you see a network provider or pharmacy versus going out of network.

Going to a network provider or pharmacy

When you use network doctors, you usually pay less, and the office staff takes care of the paperwork for you. They'll make a copy of your ID card and send a claim to us to get paid. For covered services and prescriptions, what happens next depends on the following:

If there's enough money in your HSA, you can use your HSA debit card or check to pay your share of the cost.

What if you don't have enough money left or don't feel like using your HSA? If you haven't met your deductible for the year, you'll need to pay out of your own pocket.

After you reach your yearly deductible, traditional health coverage kicks in. That's where the plan pays part of the cost for a covered service or prescription and you pay your part (coinsurance). You pay coinsurance until you reach your plan's yearly out-of-pocket maximum. Money will be taken out of your HSA to help you pay for your coinsurance.

If you meet your yearly out-of-pocket maximum, the plan will pay 100% of the cost for your covered care or prescription, up to the allowed amount. (See your plan summary for details.)

After we look at the claim, you'll get a claim summary. It shows the total cost of the service, the allowable charge (the amount the provider agreed to accept from us) and any amount you may have to pay. If you have any out-of-pocket costs, your doctor will send you a bill for that – compare that bill to your claims summary to be sure the amounts match. That amount you pay will go toward your yearly deductible and your out-of-pocket maximum.

When you fill a prescription, show your ID card to the pharmacy staff to make sure you get the right discount for your prescription. The discount will be applied at the pharmacy and you will pay the full cost of the prescription at the time of purchase. If there's enough money in your HSA, you can use your HSA debit card or check to pay. You will not receive a claim summary for your prescription drug purchases.

Going to an out-of-network provider

You can also see provider who is not in the network, and you can still use your HSA to pay for costs. But you may have to pay the full cost of the service and then send a claim to get reimbursed.

The provider may make you pay for the bill – in full – at your appointment. If the provider doesn't send us your claim, then you'll have to do it. You can get a claim form at anthem.com. We'll apply the allowable charge on covered services toward your annual deductible and out-of-pocket maximum. The provider doesn't have to accept our allowable charge and can bill you for any difference between that charge and the total bill.

How your Lumenos® with Health Savings Account (HSA) plan works (Continued)

Getting answers

Frequently asked questions about your plan

Q: Who can open an HSA?
A: To open an HSA, you have to be:

- On a health plan that is specially made to go with an HSA. Lumenos is an example of one of these health plans. If you have any secondary coverage through your spouse's plan or an executive medical plan (which is a medical plan offered through employers to executive staff members), then that plan also has to work with an HSA.
- Joining the health plan on the first day of the month. If you join later than that, then you won't be able to put money into your HSA until the first day of the next month. But no matter when you are allowed to start putting money into your HSA, you'll be able to make the maximum annual contribution for the year.
- A U.S. resident

To open an HSA, you must not be:

- A resident of American Samoa
- Enrolled in Medicare
- Eligible to be claimed as a dependent on someone's tax return
- An active member of the military

If you're a veteran, you must not have received veterans' benefits within the last three months

Q: What's the difference between an HSA and a health care flexible spending account (FSA)?
A: You can put tax-deductible money into both HSAs and FSAs and use that money toward your medical expenses. But that's the only thing that they have in common. With an HSA, if you have money left in your account at the end of the year, you can roll it over to use toward your medical expenses for the next year. And if you were to leave your job, you could take your HSA money with you.

With an FSA, you lose any money left in your account at the end of the year. And if you leave your job, you can't take your money with you.

Q: Can I have an HSA and an FSA?
A: Yes, you can have both an HSA and an FSA. But your employer must offer one of the following:

1. **A Limited/Special Purpose FSA.** This means that you can use the FSA for dental and/or vision expenses only. Or you can use it to help pay for dependent care, like daycare expenses.
2. **Limited Purpose High-Deductible FSA.** This means that you can use the FSA for dental and/ or vision expenses. And you can use it to pay coinsurance under your health plan. Coinsurance is the amount of covered expenses that you have to pay once you've met your deductible.

How your Lumenos® with Health Savings Account (HSA) plan works (Continued)

Q: How do I put money into my HSA?
A: You fund your HSA with pre-tax and post-tax money. The easiest way is to have pre-tax money taken right out of your paycheck. But you can also put post-tax money into the account by sending a check to the address printed on your HSA checkbook. Others (like your employer or family members) may deposit money into your account as well.

Q: How much can I put into my HSA each year?
A: For 2014, if you are the only one enrolled in the HSA, the most you can put into your HSA is $3,300. If you have family coverage, you can put in $6,550. This rule is set by the IRS and U.S. Treasury. Sometimes, these annual limits can change because of inflation. Check anthem.com for the most up-to-date amounts.

Q: Can I ever put more than the annual limit into my HSA?
A: If you are 55 or older and not enrolled in Medicare, you can put in an extra $1,000 above the annual limit. When you do this, it's called a catch-up contribution. You can make catch-up contributions every year until you enroll in Medicare. Only the person who holds the HSA policy can make catch-up contributions. Amounts may be prorated if you've been enrolled in the plan for less than 12 months. You can make catch-up contributions the same way you'd make regular ones.

Q: How much can I put into my account if I open my HSA after the start of the plan year?
A: You can enroll in the HSA plan only during open enrollment or when you start a new job. Sometimes, you may have a waiting period of a couple of months for coverage to start. If you join the plan during the middle of the year, you can usually put up to the annual limit in your account – as long as you enroll by December 1. And you have to stay in the HSA and remain eligible to put money into it for the entire 12 months of the following year.

Q: What if my coverage ends before the end of the year?
A: If you leave your job, you can keep putting money into your HSA only if you still have coverage in an HSA-compatible health plan. If you aren't enrolled in one, then the annual limit amount would be pro-rated based on the number of months that you were in the HSA. If you had already put the annual limit into your account before you left your job, you'd have to withdraw any money above the pro-rated amount before the end of the tax year. And you'd have to treat that money as taxable income; otherwise you'd face tax penalties.

Q: What if my spouse has an HSA, too?
A: If you or your spouse are covered under the other one's HSA, the total amount of money in both accounts can't be more than the annual family limit.

Q: What if I have money left in my HSA at the end of each plan year?
A: Whatever you don't spend is yours to keep. You can save it in your HSA, year after year, to help you pay for future medical expenses.

Q: What kinds of health expenses does the Lumenos plan cover?
A: The Lumenos plan covers typical health expenses from office visits and prescription drugs to major surgery. These health expenses are called qualified health expenses. You can use the money in your HSA to pay your deductible and out-of-pocket maximums for these expenses. To see a list of some of the expenses covered by your plan, check your plan summary.

How your Lumenos® with Health Savings Account (HSA) plan works (Continued)

Q: How are routine checkups and health screenings (like physicals and mammograms) covered?
A: The Lumenos plan covers "preventive care" like physicals, shots and mammograms at 100% when you see a network doctor. You won't have to pay anything out of your own pocket. If you see an out-of-network doctor, you'll have to meet your deductible. If that is met, then you'll pay coinsurance. The coinsurance will go toward your out-of-pocket maximum. You can use your HSA money to cover these costs.

Q: Does the Lumenos plan cover prescription drugs?
A: Yes. You can pay for your prescription drugs with the money in your HSA. If you don't have any money left in your HSA or don't want to use that money, you will have to pay for the prescriptions out of your own pocket until you meet your deductible. After you meet the deductible amount, then you may have to pay coinsurance or a copay. To find out more about prescription coverage, see the section ***Your prescription drug plan***.

Q: Can I use HSA money to pay for health expenses that aren't covered by Lumenos?
A: Yes. These are called nonqualified expenses. They're defined in Section 213d of the IRS Code. For a list of these expenses, please visit the IRS website at irs.gov and type "Publication 502" in the search box. Keep in mind that when you use your HSA to pay for nonqualified expenses, the amount you spend will not count toward your deductible or out-of-pocket maximum. And it will be considered part of your taxable income. You will also owe a 20% penalty on the amount.

Q: Who holds the money in my HSA?
A: A qualified financial institution (like a bank) will hold and invest your money. If your employer picks a bank that we partner with, then we can take care of the enrollment for you.

Q: How do I find out my HSA balance?
A: It's easy. First register at anthem.com and then log in. Once in your account, you can see your balance and keep track of all the activity (like deposits and withdrawals) that has taken place. You can also see your health and pharmacy claims. Four times a year, we'll send you a statement that shows you all of your claims. It'll also give you any important messages about how you can improve your health and even save money.

Q: If I leave the Lumenos plan, what happens to my HSA?
A: You own your HSA. That means if you leave the Lumenos plan or your job, you can take it with you and use it for whatever you'd like. Once you retire, for example, you can use it to pay for Medicare premiums. It's up to you if you want to keep the funds in your account or roll them into a different one. If you leave them in your account, some fees will apply. You can find a list of these fees in the Health Savings Account Deposit Agreement and Disclosure Statement. Note: If you keep your HSA after leaving the Lumenos plan, you can't continue to contribute to it unless you enroll in another HSA-compatible plan.

Anthem

Lumenos

Lumenos HSA Plan Summary

The Lumenos® HSA plan is designed to empower you to take control of your health, as well as the dollars you spend on your health care. This plan gives you the benefits you would receive from a typical health plan, plus health care dollars to spend your way. And, you can earn rewards by taking certain steps to improve your health.

Your Lumenos HSA Plan

First - Use your HSA to pay for covered services:

Health Savings Account

With the Lumenos Health Savings Account (HSA), you can contribute pre-tax dollars to your HSA account. Others may also contribute dollars to your account. You can use these dollars to help meet your annual deductible responsibility. Unused dollars can be saved or invested and accumulate through retirement.

Contributions to Your HSA

For 2014, contributions can be made to your HSA up to the following:
$3,300 individual coverage
$6,550 family coverage

Note: These limits apply to all combined contributions from any source.

Plus - To help you stay healthy, use:

Preventive Care

100% coverage for nationally recommended services. Included are the preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits.

Preventive Care

No deductions from the HSA or out-of-pocket costs for you as long as you receive your preventive care from an in-network provider. If you choose to go to an out-of-network provider, your deductible or Traditional Health Coverage benefits will apply.

Then -

Your Bridge Responsibility

The Bridge is an amount you pay out of your pocket until you meet your annual deductible responsibility. Your bridge amount will vary depending on how many of your HSA dollars, if any, you choose to spend to help you meet your annual deductible responsibility. If you contribute HSA dollars up to the amount of your deductible and use them, your Bridge will equal $0.

HSA dollars spent on covered services plus your Bridge Responsibility add up to your annual deductible responsibility.

Health Account + Bridge = Deductible

Bridge

Your Bridge responsibility will vary.

Annual Deductible Responsibility
$1,500 individual coverage
$3,000 family coverage

If Needed -

Traditional Health Coverage

Your Traditional Health Coverage begins after you have met your Bridge responsibility.

Traditional Health Coverage

After your bridge, the plan pays:
100% for in-network providers 80% for out-of-network providers

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Additional Protection

For your protection, the total amount you spend out of your pocket is limited. Once you spend that amount, the plan pays 100% of the cost for covered services for the remainder of the plan year.

Annual Out-of-Pocket Maximum

In-Network and Out-of-Network Providers
$3,000 individual coverage
$6,000 family coverage

Your annual out-of-pocket maximum consists of funds you spend from your HSA, your Bridge responsibility and your coinsurance amounts.

And even -

Earn Rewards

What's special about your Lumenos HSA plan is that you may earn reward dollars to redeem for gift cards to select retailers. It's how your Lumenos plan rewards you for taking steps to improve your health.

Earn Rewards

If you do this:	You can earn:
Complete the MyHealth Assessment online	$50
Enroll in the MyHealth Coach Program	$100
Graduate from the MyHealth Coach Program	$200
Complete our Tobacco Free Program	$50
Complete our Healthy Weight Program	$50

Some eligibility requirements apply. See page 2 for program descriptions..

If you have questions, please call toll-free 1-888-224-4896.

Group Gift Card

Cooperative Educational Services
CGHSA579 w GC NGF (1/14)

Healthy Rewards

You can earn reward dollars to redeem for gift cards at select retailers. Earn rewards for the following:

• **MyHealth Assessment:** You and your family members can complete the MyHealth Assessment, our online tool designed to help measure your overall health. One adult family member is eligible to earn $50 per plan year. The health information you provide is strictly confidential.

• **MyHealth Coach:** If you qualify for the MyHealth Coach Program, you'll receive one-on-one assistance from a specially trained registered nurse to help you manage a health condition. Health conditions may include but are not limited to diabetes, asthma, depression, high blood pressure, heart disease and pregnancy. You'll receive $100 for enrolling in the MyHealth Coach Program (one reward per covered person per year). You'll receive $200 for achieving your health goals and graduating from the MyHealth Coach Program (one reward per covered person per year).

• **Tobacco Free Program:** This program helps you manage withdrawal symptoms, identify triggers and learn new behaviors and skills to remain tobacco free. Participation is open to you and your covered family members age 18 or older, and includes counseling support and tools, including nicotine-replacement therapy coverage. You and your spouse are eligible to receive $50 (one reward per person per lifetime) for completing this program.

• **Healthy Weight Program:** Our Healthy Weight Program is a personalized phone course designed to help you adopt lifestyle changes necessary to lose weight and maintain weight loss. A team of counselors (a registered dietitian and health educator) with expertise in weight management will help you address healthy eating, physical activity and exercise, stress management, and more. You and your covered family members age 18 and older who have a Body Mass Index (BMI) of 25 or higher are eligible for this program. You and your spouse are eligible to receive $50 (one reward per person per lifetime) for completing the program.

Summary of Covered Services

Preventive Care

Anthem's Lumenos HSA plan covers preventive services recommended by the U.S. Preventive Services Task Force, the American Cancer Society, the Advisory Committee on Immunization Practices (ACIP) and the American Academy of Pediatrics. The Preventive Care benefit includes screening tests, immunizations and counseling services designed to detect and treat medical conditions to prevent avoidable premature injury, illness and death.

All preventive services received from an in-network provider are covered at 100%, are not deducted from your HSA and do not apply to your deductible. If you see an out-of-network provider, then your deductible or out-of-network coinsurance responsibility will apply.

The following is a list of covered preventive care services:

Well Baby and Well Child Preventive Care

Office Visits through age 18; preventive vision exams including an annual refraction.

Screening Tests for vision, hearing, and lead exposure. Also includes pelvic exam, Pap test and contraceptive management for females who are age 18, or have been sexually active.

Immunizations:
Hepatitis A
Hepatitis B
Diphtheria, Tetanus, Pertussis (DtaP)
Varicella (chicken pox)
Influenza – flu shot
Pneumococcal Conjugate (pneumonia)
Human Papilloma Virus (HPV) – cervical cancer
H. Influenza type b
Polio
Measles, Mumps, Rubella (MMR)

Adult Preventive Care

Office Visits after age 18; preventive vision exams including an annual refraction.

Screening Tests for vision and hearing, coronary artery disease, colorectal cancer, prostate cancer, diabetes, and osteoporosis. Also includes mammograms, as well as pelvic exams, Pap test and contraceptive management.

Immunizations:
Hepatitis A
Hepatitis B
Diphtheria, Tetanus, Pertussis (DtaP)
Varicella (chicken pox)
Influenza – flu shot
Pneumococcal Conjugate (pneumonia)
Human Papilloma Virus (HPV) – cervical cancer

Summary of Covered Services (Continued)

Medical Care

Anthem's Lumenos HSA plan covers a wide range of medical services to treat an illness or injury. You can use your available HSA funds to pay for these covered services. Once you spend up to your deductible amount shown on Page 1 for covered services, you will have Traditional Health Coverage with the coinsurance listed on Page 1 to help pay for covered services listed below:

- Physician Office Visits
- Inpatient Hospital Services
- Outpatient Surgery Services
- Diagnostic X-rays/Lab Tests
- Durable Medical Equipment
- Emergency Hospital Services (network coinsurance applies both in-network and out-of-network)
- Inpatient and Outpatient Mental Health and Substance Abuse Services
- Maternity Care
- Chiropractic Care
- Prescription Drugs
- Home health care and hospice care
- Physical, Speech and Occupational Therapy Services

Some covered services may have limitations or other restrictions.* With Anthem's Lumenos HSA plan, the following services are limited:

- Skilled nursing facility services are covered up to an unlimited maximum.
- Home Health care services limited to 200 visits per member per calendar year and are subject to 25% coinsurance when services are rendered out-of-network.
- Inpatient rehabilitative services limited to 100 days per member per calendar year.
- PT/OT/ST and chiropractic services limited to a combined total of 60 visits per member per calendar year.
- Home Hospice services are subject to deductible and 25% coinsurance when services are rendered out-of-network.
- In-and out-of-network ER and Ambulance services are paid at 100% after deductible.
- Durable Medical Equipment covered at 100% after deductible in-network and out-of-network.
- Acupuncture limited to 20 visits per member per calendar year.
- Oral surgery for the extraction of impacted wisdom teeth is covered at 100% after deductible.
- Infertility services are covered up to an unlimited maximum.
- Inpatient hospitalizations require authorizations.
- Your Lumenos HSA plan includes an unlimited lifetime maximum per member per calendar year for in- and out-of-network services.

* For a complete list of exclusions and limitations, please reference your Certificate of Coverage.

This summary is a brief outline of the benefits and coverage provided under the Lumenos plan. It is not intended to be a complete list of the benefits of the plan. This summary is for a full year in the Lumenos plan. If you join the plan mid-year or have a qualified change of status, your actual benefit levels may vary.

When you redeem your Healthy Rewards dollars for a gift card, the amount of the gift card is considered taxable income to you. You should contact a tax advisor for guidance on tax issues.

Additional limitations and exclusions may apply.

If you have questions, please call toll-free 1-888-224-4896.

Take care of yourself

Remember to get preventive care

Getting regular checkups and exams can help you stay well and catch problems early. It may even save your life.

Our health plans cover 100% of the services listed in this preventive care flier.[1] When you get these services from doctors in your plan's network, you don't have to pay anything out of your own pocket. You may have to pay part of the costs if you use a doctor outside the network.

Preventive versus diagnostic care

What's the difference? Preventive care helps protect you from getting sick. Diagnostic care is used to find the cause of existing illnesses.

For example, say your doctor suggests you have a colonoscopy because of your age. That's preventive care. On the other hand, say your doctor suggests a colonoscopy to see what's causing your symptoms. That's diagnostic care and you may need to pay part of the cost.

Here's a listing of the types of preventive services we cover. See your benefit plan to learn more.

Child preventive care (birth through 21 years)

Preventive care physical exams are covered. So are the screenings, tests and vaccines listed here. The preventive care services listed below may not be right for every person. Ask your doctor what's right for you.

Preventive physical exams

Screening tests (depending on your age) may include

- Behavioral counseling to promote a healthy diet
- Blood pressure
- Cervical dysplasia screening
- Cholesterol and lipid level
- Depression screening
- Development and behavior screening
- Fluoride supplements for children from birth through 6 years old[6]
- Hearing screening
- Height, weight and body mass index (BMI)
- Hemoglobin or hematocrit (blood count)
- HPV screening (female)
- Iron supplements for children 0-12 months[6]
- Lead testing
- Newborn screening
- Screening and counseling for obesity
- Oral (dental health) assessment when done as part of a preventive care visit
- Screening and counseling for sexually transmitted infections
- Type 2 diabetes screening
- Vision screening[2] when done as part of a preventive care visit

Take care of yourself (continued)

Immunizations

- Diphtheria, tetanus and pertussis (whooping cough)
- Haemophilus influenza type b (Hib)
- Hepatitis A
- Hepatitis B
- Human papillomavirus (HPV)
- Influenza (flu)
- Measles, mumps and rubella (MMR)
- Meningococcal (meningitis)
- Pneumococcal (pneumonia)
- Polio
- Rotavirus
- Varicella (chicken pox)

Adult preventive care (22 years and older)

Preventive care physical exams are covered. So are the screenings, tests and vaccines listed here. The preventive care services listed below may not be right for every person. Ask your doctor what's right for you.

Preventive physical exams

Screening tests and services (depending on your age) may include

- Aortic aneurysm screening (men who have smoked)
- Blood pressure
- Bone density test to screen for osteoporosis
- Breast cancer, including exam and mammogram
- Breastfeeding support, supplies and counseling (female)[3, 4]
- Cholesterol and lipid (fat) level
- Colorectal cancer, including fecal occult blood test, barium enema, flexible sigmoidoscopy, screening colonoscopy and CT colonography (as appropriate)
- Contraceptive (birth control) counseling and FDA-approved contraceptive medical services provided by a doctor, including sterilization (female), and FDA-approved prescribed or women's over-the-counter contraceptives[4, 5]
- Depression screening
- Eye chart test for vision[2]
- Hearing screening
- Height, weight and BMI
- HIV screening and counseling
- HPV (female)[4]
- Intervention services (includes counseling and education):
  - Behavioral counseling to promote a healthy diet
  - Counseling related to aspirin use for the prevention of cardiovascular disease including aspirin for men ages 45-79 and women ages 55-79[6]
  - Counseling related to genetic testing for women with a family history of ovarian or breast cancer, including genetic testing for BRCA 1 and BRCA 2 when certain criteria are met[7]
  - Counseling related to chemoprevention for women with a high risk of breast cancer

Take care of yourself (continued)

- Folic acid for women 55 years old or younger[6]
- Primary care intervention to promote breastfeeding[3,4]
- Screening and behavioral counseling related to alcohol misuse
- Screening and behavioral counseling related to tobacco use including tobacco cessation products[8]
- Screening and counseling for interpersonal and domestic violence
- Screening and counseling for obesity
- Vitamin D for women over 65

- Pelvic exam and Pap test, including screening for cervical cancer
- Prostate cancer, including digital rectal exam and PSA test
- Screenings during pregnancy (including, but not limited to, gestational diabetes, hepatitis, asymptomatic bacteriuria, Rh incompatibility, syphilis, iron deficiency anemia, gonorrhea, chlamydia and HIV)[4]
- Screening and counseling for sexually transmitted infections

Immunizations

- Diphtheria, tetanus and pertussis (whooping cough)
- Hepatitis A
- Hepatitis B
- HPV
- Influenza (flu)
- Meningococcal (meningitis)
- MMR
- Pneumococcal (pneumonia)
- Varicella (chicken pox)
- Zoster (shingles)

This sheet is not a contract or policy with Anthem Blue Cross and Blue Shield. If there is any difference between this sheet and the group policy, the provisions of the group policy will govern. Please see your combined Evidence of Coverage and Disclosure Form or Certificate for Exclusions & Limitations.

1 The range of preventive care services covered at no cost share when provided in-network are designed to meet the requirements of federal and state law. The Department of Health and Human Services has defined the preventive services to be covered under federal law with no cost share as those services described in the U.S. Preventive Services Task Force A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), and certain guidelines for infants, children, adolescents and women supported by the Health Resources and Services Administration (HRSA) Guidelines. You may have additional coverage under your insurance policy. To learn more about what your plan covers, see your certificate of coverage or call the Customer Care number on your ID card.

2 Some plans cover additional vision services. Please see your contract or Certificate of Coverage for details.

3 Breast pumps and supplies must be purchased from an in-network medical provider for 100% coverage; we recommend using an in-network durable medical equipment (DME) supplier.

4. This benefit also applies to those younger than 22.

5 To get 100% coverage for birth control, you must present a prescription at an in-network pharmacy for a generic drug, a brand-name drug that doesn't have a generic equivalent, or an OTC item like female condoms or spermicide. A cost share may apply for other prescription contraceptives, based on your drug benefits.

6. To get 100% coverage, you will need to present a prescription from a doctor or other health care provider at an in-network pharmacy.

7. Check your medical policy for details.

8. For those 21 years and older. 100% coverage of tobacco cessation products requires a prescription from a doctor that must be presented at an in-network pharmacy. Coverage is provided for select generic products, brand-name products with no generic alternatives, and FDA-approved over-the-counter products.

Coverage While Traveling

Whether you're traveling on business, away for fun or have been stationed in another state, your coverage travels with you. The BlueCard® program makes sure of that by uniting Anthem's network with those of other Blue Cross and Blue Shield companies across the U.S. You'll have access to medical care most anywhere you're staying.

It's as easy as accessing your local network.

Getting medical care away from home is as convenient as accessing the local network — with just one added step.

1. Find a provider from the BlueCard listing. Like when at home, you can search online at anthem.com or call the member services number on the back of your member ID card. You can also call BlueCard Access at 800-810-BLUE (2583).
2. (This is the additional step.) Call Anthem member services to verify your coverage.
3. Show your ID card at the time of service.

One additional step. No additional costs or hassles. You pay the same with any Blue Cross and Blue Shield provider as you would an Anthem network provider. Plus the provider will file your claims for you. Anthem will still mail your explanation of benefits so you can double check how the service was covered.

As always, if you need emergency care, you should go to the nearest hospital without contacting Anthem first. Just give us a call within 24 hours or as soon as reasonably possible.

Enjoy your travels. We're happy to go with you.

Your pharmacy benefits

We're glad you're part of our prescription drug plan. We think it's important for you to have access to a wide range of affordable medicines. And we work hard to provide you with the best service. If you have any questions about your plan, call us at the phone number on your member ID card.

Save money on your prescriptions

Here are some easy ways to get the most from your plan – and save on your medicine.

Choose the drugs you need from our drug list

Our drug list (sometimes called a formulary) is a list of prescription drugs covered by your plan. It's made up of hundreds of brand-name and generic drugs. We research drugs and choose ones that are safe, work well and offer the best value. Sometimes we update the drug list when new drugs come to market, or if new research becomes available. If your plan uses a tiered drug list, view the drugs we cover at www.anthem.com/national3tier.

You'll save money by taking medicines that are on the drug list. Drugs that aren't on the list may have a higher copay or may not be covered, depending on your plan.

Also, some drugs need our review and need to get an OK from us before the prescription is filled to make sure they're covered. This is called **prior authorization**. This review focuses mainly on drugs that may have:

- A risk of serious side effects or drug interactions
- High potential for incorrect use or abuse
- Better alternatives that may cost less
- Rules for use with very specific conditions

Your pharmacist will tell you if your drug needs prior authorization.

Try generic drugs

Generics drugs cost much less than most brand-name drugs. So ask your doctor if a there's a generic choice for your medicine – and if it might work for you. Generic drugs are approved by the Food and Drug Administration (FDA) and work as well as the brand-name choices.

Use over-the-counter (OTC) drugs when you can

You don't need a prescription for OTC drugs. They often have the same active ingredients as the prescription versions but usually cost a lot less. OTC allergy and heartburn medicines are good examples. Just ask your doctor if it's okay to swap your prescription drug for an OTC medicine.

Your pharmacy benefits (continued)

Visit in-network pharmacies

Our retail pharmacy network includes more than 64,000 pharmacies across the country, including major chains, grocery stores and independent pharmacies. That means you have easy access to your medicine wherever you are – at work, at home or even on vacation. Using pharmacies in the network will help save money. And when picking up your prescription at the pharmacy, don't forget to show your member ID card.

To make sure your pharmacy is in our network, visit anthem.com. Click on **Prescription Benefits** and sign in. On the pharmacy page, click on **Locate a Pharmacy**.

Sign up for our convenient Home Delivery Pharmacy

Home delivery is a safe, easy way to get medicine you need on a regular basis. Prescriptions are sent to your home within two weeks from the time the pharmacy gets your order. Pharmacists can answer your drug questions by phone any time. Plus, you may be able to save money on your medicine.

Our Home Delivery Pharmacy is managed by Express Scripts. See the next page to learn how to get started.

Get support from our specialty pharmacy

Accredo, the Express Scripts specialty pharmacy, provides medicine and support and for people with complex and long-term conditions. Specialty drugs come in different forms like pills or liquids. And some need to be injected, infused or inhaled. These drugs often need special storage and handling and may be given to you by a doctor or nurse.

Accredo's programs help people with some complex conditions. These programs teach you about treatment for your condition and help you understand and cope with drug side effects.Nurses and pharmacists will even set up time with you to find out how you are doing.

Call 888-773-7376, Monday through Friday, 8 a.m. to 9 p.m., Eastern time, to learn how Accredo's condition support programs can help you better manage your health condition.

Information at your fingertips

Wherever you are, you can easily access your pharmacy information online.

Check out anthem.com.

Simply click on Prescription Benefits and sign in. Once you're signed in, you'll have access to lots of tools and drug information, all in one spot. You can check order status, order refills, price a drug, renew a prescription and much more. And when you're on the go, just download the Anthem app from the Apple Store or Android Market. Everything you can do online, you can do from your smartphone!

EXPRESS SCRIPTS®

HOME DELIVERY PHARMACY ORDER FORM

To MAIL your prescription:
1. "Patient" box must be filled out.
2. Have your Doctor write a prescription.
3. Send your new prescription along with this completed form to:
   Express Scripts Home Delivery Service
   PO Box 66785
   St. Louis MO 63166-6785

To FAX your prescription:
1. Both "Dr/Prescriber" and "Rx Form" boxes must be filled out.
2. Doctor can fax to: 1-800-600-8105
   - **Class II prescriptions cannot be faxed.**
   - Faxes will only be accepted from a doctor's office.

PATIENT

Member ID: _____

First Name: _____ Last Name: _____

Date of Birth: _____ Phone: _____

Address: _____

_____

_____

E-mail: _____

Allergies: _____

_____

Health Conditions: _____

_____

_____

Over-the-Counter Medications: _____

_____

DOCTOR/PRESCRIBER

DEA: _____

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

PATIENT OPTIONS

☐ I want non-child resistant caps, when available.
☐ I want a copy of my bottle label in large print on a separate sheet of paper.
☐ Check here for rush delivery. Once your order is received and filled, it will be shipped overnight for $21.

If you want to make a payment or update your health conditions, please visit your health plan provider's website.

2161

Rx

_____ _____ **Date:** __ __ / __ __ / __ __

First Name **Last Name**

Drug Name/Form/Strength	Qty	Directions for Use	Refills

X _____ **X** _____

Doctor/Prescriber Signature – Substitution Permissible

Doctor/Prescriber Signature – Dispense as Written

Stamped signatures cannot be accepted.

Information You Should Know

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

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

Utilization management

Utilization management (UM) is a program that is part of your health plan. It lets us make sure you're getting the right care at the right time. Our UM review team, made up of licensed health care professionals such as nurses and doctors, do 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 needed. The UM review team checks to make sure the treatment meets certain rules set by your health plan. After reviewing the records and information, the team will approve (cover) or deny (not cover) the treatment. The UM review team will let you and your doctor know as soon as possible.

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

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

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

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

The concurrent review (done during medical care and recovery)

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

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

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

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

Case management

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

Preauthorization

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

Here's how getting preauthorization can help you out:

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

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

What can you do? Choose an in-network doctor. Talk to your doctor about your conditions and treatment options. Ask your doctor which covered services need preauthorization or call us to ask. The doctor's office will ask for preauthorization for you. Plus, costs are usually lower with in-network doctors.

If you choose an out-of-network provider, be sure to call us to see if you need preauthorization. Non-network providers may not do that for you. If you ever have a question about whether you need preauthorization, just call the preauthorization or precertification phone number on your ID card.

There are times when we may need to do a benefit review for a health care service you plan to receive or have already received. We do this to find out what your plan will cover for that service. During the review, we take a look at the terms, benefits, limitations and exclusions of your particular plan. This means we may check to see if your plan covers the service, if you've already reached a benefit limit for the service, and if you can see a provider outside of the network. We may also review other aspects of your plan.

Your rights and responsibilities as a member

As a member you have certain rights and responsibilities to help make sure that you get the most from your plan and access to the best care possible. That includes certain things about your care, how your personal information is shared and how you work with us and your doctors. It's kind of like a "Bill of Rights". And helps you know what you can expect from your overall health care experience and become a smarter health care consumer.

You have the right to:

- Speak freely and privately with your doctors and other health professionals about all health care options and treatment needed for your condition, no matter what the cost or whether it's covered under your plan.
- Work with your doctors in making choices about your health care.
- Be treated with respect, dignity, and the right to privacy.
- Privacy, when it comes to your personal health information, as long as it follows state and federal laws, and our privacy rules.
- Get information about our company and services, and our network of doctors and other health care providers.
- Get more information about your rights and responsibilities and give us your thoughts and ideas about them.
- Give us your thoughts and ideas about any of the rules of your health care plan and in the way your plan works.
- Make a complaint or file an appeal about:
  - Your health care plan
  - Any care you get
  - Any covered service or benefit ruling that your health care plan makes
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future; and the right to have your doctor tell you how that may affect your health now and in the future
- Participate in matters that deal with the company policies and operations.
- Get all of the most up-to-date information about the cause of your illness, your treatment and what may result from that illness or treatment from a doctor or other health care professional. When it seems that you will not be able to understand certain information, that information will be given to someone else that you choose.
- Get help at any time, by contacting your local insurance department.

Your rights and responsibilities as a member (continued)

You have the responsibility to:

- Choose any primary care physician (doctor), also called a PCP, who is in our network if your health care plan says that you to have a PCP.
- Treat all doctors, health care professionals and staff with courtesy and respect.
- Keep all scheduled appointments with your health care providers and call their office if you have a delay or need to cancel.
- Read and understand, to the best of your ability, all information about your health benefits or ask for help if you need it.
- To the extent possible, understand your health problems and work with your doctors or other health care professionals to make a treatment plan that you all agree on.
- Follow the care plan that you have agreed on with your doctors or health care professionals.
- Tell your doctors or other health care professionals if you don't understand any care you're getting or what they want you to do as part of your care plan.
- Follow all health care plan rules and policies.
- Let our Customer Service department know if you have any changes to your name, address or family members covered under your plan.
- Give us, your doctors and other health care professionals the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health care plans and insurance benefits you have in addition to your coverage with us.

For details about your coverage and benefits, please read your "Subscriber Agreement".

Important legal information you should take time to read

Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act explains your rights for treatment under the health plans if you need a mastectomy. Plain and simple ... we're here for you.

If you ever need a benefit-covered mastectomy, we hope it will give you some peace of mind to know that your Anthem Blue Cross and Blue Shield benefits comply with the Women's Health and Cancer Rights Act of 1998, which provides for:

- Reconstruction of the breast(s) that underwent a covered mastectomy.
- Surgery and reconstruction of the other breast to restore a symmetrical appearance.
- Prostheses and coverage for physical complications related to all stages of a covered mastectomy, including lymphedema.
- All applicable benefit provisions will apply, including existing deductibles, copayments and/or coinsurance.

HIPAA Notice of Privacy Practices

The HIPAA Notice of Privacy Practices explains the rules around how we handle your private information under HIPAA laws. Plain and simple ... we don't share your information unless it's needed to manage your benefits or you give us the OK to do it.

We keep the health and financial information of our current and former members private as required by law, accreditation standards, and our rules. This notice explains your rights. It also explains our legal duties and privacy practices. We are required by federal law to give you this notice.

Your Protected Health Information

We may collect, use, and share your Protected Health Information (PHI) for the following reasons and others as allowed or required by law, including the HIPAA Privacy rule:

For payment: We use and share PHI to manage your account or benefits; or to pay claims for health care you get through your plan. For example, we keep information about your premium and deductible payments. We may give information to a doctor's office to confirm your benefits.

For health care operations: We use and share PHI for our health care operations. For example, we may use PHI to review the quality of care and services you get. We may also use PHI to provide you with case management or care coordination services for conditions like asthma, diabetes, or traumatic injury.

For treatment activities: We do not provide treatment. This is the role of a health care provider such as your doctor or a hospital. But, we may share PHI with your health care provider so that the provider may treat you.

To you: We must give you access to your own PHI. We may also contact you to let you know about treatment options or other health-related benefits and services. When you or your

Important legal information you should take time to read (continued)

dependents reach a certain age, we may tell you about other products or programs for which you may be eligible. This may include individual coverage. We may also send you reminders about routine medical checkups and tests.

To others: You may tell us in writing that it is OK for us to give your PHI to someone else for any reason. Also, if you are present, and tell us it is OK, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are not present, if it is an emergency, or you are not able to tell us it is OK, we may give your PHI to a family member, friend or other person if sharing your PHI is in your best interest.

As allowed or required by law: We may also share your PHI, as allowed by federal law, for many types of activities. PHI can be shared for health oversight activities. It can also be shared for judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and to coroners, funeral directors or medical examiners (about decedents). PHI can also be shared for certain reasons with organ donation groups, for research, and to avoid a serious threat to health or safety. It can be shared for special government functions, for workers' compensation, to respond to requests from the U.S. Department of Health and Human Services and to alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or other crimes. PHI can also be shared as required by law.

If you are enrolled with us through an employer-sponsored group health plan, we may share PHI with your group health plan. We and/or your group health plan may share PHI with the sponsor of the plan. Plan sponsors that receive PHI are required by law to have controls in place to keep it from being used for reasons that are not proper.

Authorization: We will get an OK from you in writing before we use or share your PHI for any other purpose not stated in this notice. You may take away this OK at any time, in writing. We will then stop using your PHI for that purpose. But, if we have already used or shared your PHI based on your OK, we cannot undo any actions we took before you told us to stop.

Genetic information: If we use or disclose PHI for underwriting purposes, we are prohibited from using or disclosing PHI that is genetic information of an individual for such purposes.

Your rights

Under federal law, you have the right to:

- Send us a written request to see or get a copy of certain PHI or ask that we correct your PHI that you believe is missing or incorrect. If someone else (such as your doctor) gave us the PHI, we will let you know so you can ask them to correct it.
- Send us a written request to ask us not to use your PHI for treatment, payment or health care operations activities. We are not required to agree to these requests.
- Give us a verbal or written request to ask us to send your PHI using other means that are reasonable. Also let us know if you want us to send your PHI to an address other than your home if sending it to your home could place you in danger.
- Send us a written request to ask us for a list of certain disclosures of your PHI.

Important legal information you should take time to read (continued)

Call Customer Service at the phone number printed on your identification (ID) card to use any of these rights. They can give you the address to send the request. They can also give you any forms we have that may help you with this process.

How we protect information

We are dedicated to protecting your PHI. We set up a number of policies and practices to help make sure your PHI is kept secure.

We keep your oral, written, and electronic PHI safe using physical, electronic, and procedural means. These safeguards follow federal and state laws. Some of the ways we keep your PHI safe include offices that are kept secure, computers that need passwords, and locked storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. The policies limit access to PHI to only those employees who need the data to do their jobs. Employees are also required to wear ID badges to help keep people, who do not belong, out of areas where sensitive data is kept. Also, where required by law, our affiliates and non-affiliates must protect the privacy of data we share in the normal course of business. They are not allowed to give PHI to others without your written OK, except as allowed by law.

Potential impact of other applicable laws

HIPAA (the federal privacy law) generally does not preempt, or override other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to provide you with more privacy protections, then we must also follow that law in addition to HIPAA.

Complaints

If you think we have not protected your privacy, you can file a complaint with us. You may also file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services. We will not take action against you for filing a complaint.

Contact information

Please call Customer Service at the phone number printed on your ID card. They can help you apply your rights, file a complaint, or talk with you about privacy issues.

Copies and changes

You have the right to get a new copy of this notice at any time. Even if you have agreed to get this notice by electronic means, you still have the right to a paper copy. We reserve the right to change this notice. A revised notice will apply to PHI we already have about you as well as any PHI we may get in the future. We are required by law to follow the privacy notice that is in effect at this time. We may tell you about any changes to our notice in a number of ways. We may tell you about the changes in a member newsletter or post them on our website. We may also mail you a letter that tells you about any changes.

Important legal information you should take time to read

Si necesita ayuda en espanol para entender este documento, puede solicitarla sin costo adicional, llamando al numero de servicio al cliente que aparece al dorso de su tarjeta de identificacion o en el folleto de inscripcion.

This Notice is provided by the following company: **Anthem Blue Cross and Blue Shield**

State Notice of Privacy Practices

As we told you in our HIPAA notice, we must follow state laws that are more strict than the federal HIPAA privacy law. This notice explains your rights and our legal duties under state law.

Your personal information

We may collect, use and share your nonpublic personal information (PI) as described in this notice.

We may collect PI about you from other persons or entities such as doctors, hospitals, or other carriers.

We may share PI with persons or entities outside of our company without your OK in some cases.

If we take part in an activity that would require us to give you a chance to opt-out, we will contact you. We will tell you how you can let us know that you do not want us to use or share your PI for a given activity.

You have the right to access and correct your PI.

Because PI is defined as any information that can be used to make judgments about your health, finances, character, habits, hobbies, reputation, career and credit, we take reasonable safety measures to protect the PI we have about you.

A more detailed state notice is available upon request. Please call the phone number printed on your ID card.

Connecticut disclosure of medical loss ratio

What is medical loss ratio?

This phrase means the amount of money we bring in from our customers, compared to the amount of money we pay out in claims. Connecticut law has rules for how to calculate this. For 2010, our Medical Loss Ratio was 83.1% for HMO plans and 80.5% for PPO/Indemnity plans.

Si necesita ayuda en espanol para entender este documento, puede solicitarla sin costo adicional, llamando al numero de servicio al cliente que aparece al dorso de su tarjeta de identificacion o en el folleto de inscripcion.

Special enrollment rights

This notice explains how you and your dependents (who are not covered by Anthem) have the right to enroll on a special basis.

There are certain times when you can enroll during non-enrollment periods

When you enroll in a new health plan, there is usually only one time per year that you can make any changes to your plan. This is called open enrollment. If you choose not to enroll during open enrollment, there are special instances when you are allowed to enroll yourself and your dependents. They are the following:

- **If you had another health plan that was canceled**
  If you, your dependents or your spouse are no longer eligible for other coverage (or if an employer stops contributing to your health plan), you may be able to enroll with Anthem. You must ask us to enroll within 31 days after the other coverage ends (or after the employer stops paying for it).

  For example: Let's say you and your family are enrolled through your spouse's coverage at work. Your spouse's employer stops paying for health coverage. In this case, you and your spouse, as well as other dependents on your plan, may be able to enroll in one of our health plans.

- **If you have a new dependent**

  This could mean a life event like a new marriage, birth, adoption or if you have custody of a minor and an adoption is pending. You must ask to enroll within 31 days after the event.

  For example: If you got married, your new spouse and any new children would be new dependents and may be eligible to enroll in the plan.

- **If you are a Medicaid or SCHIP plan member, you have a special period of 60 days to enroll if:**

  – You (or your eligible dependents) lose coverage because you are no longer eligible

  – You (or eligible dependents) become eligible to get help from Medicaid or SCHIP for paying part of the cost

To ask for a special enrollment or to get more information, call customer service at 207-822-7272 or 800- 482-0966.

Once you're a member, it's easy to get answers to any questions about your plan.

Just call the number on the back of your member identification (ID) card after you get it.