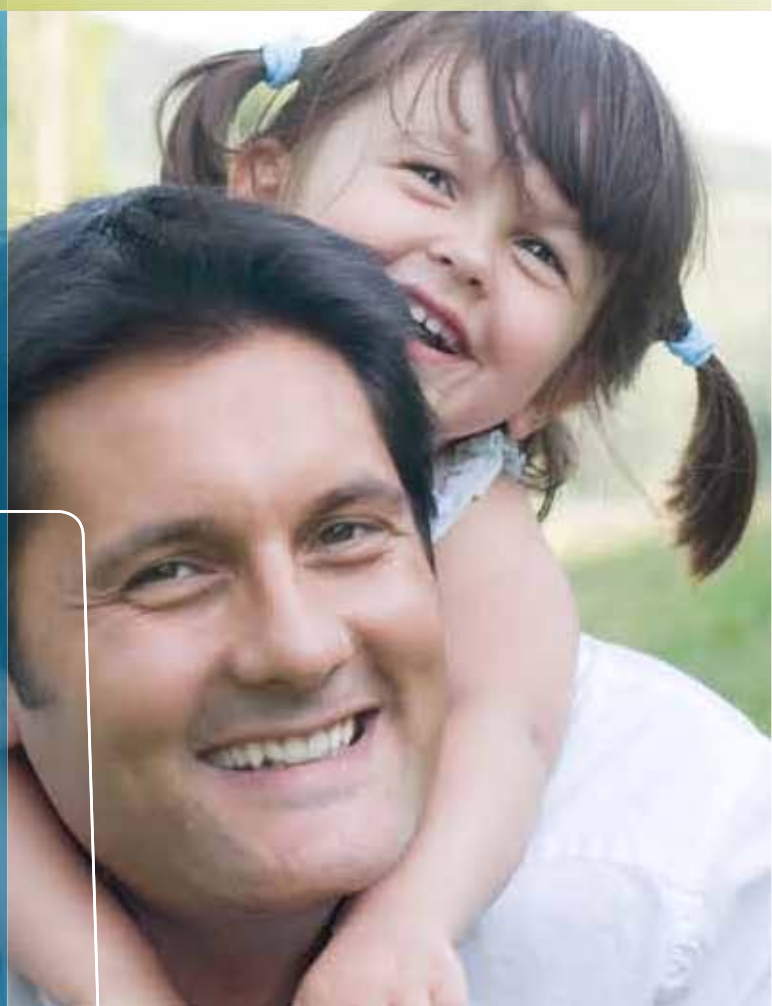
Anthem
Health. Join In.℠

Benefits You Can Count On

Blue Access PPO
ASO

Choosing the right health plan is a very personal thing.



Use this book to find one that's

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

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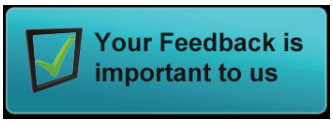
Your Feedback is
important to us

Your guide to Anthem Blue Cross Blue Shield benefits

Welcome! We're so glad you're taking time to check out all that Anthem Blue Cross Blue Shield (Anthem) 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 Anthem plan. It shows what's available to you, what you get with each benefit and how the plan works.

Explore the advantages of being an Anthem member.

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

1. **You're covered even when travel away from home.** You have access to the BlueCard® program and the BlueCard Worldwide® program so you'll be able to find an in-network doctor or hospital across the country or around the world if you need care. Wherever you travel, you can have peace of mind knowing you're covered.
2. **You get more than just basic coverage.** You get access to tools, resources and guidance that are personalized just for you. Plus there are programs to help you get and stay healthy, some are even online. 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. You can:
   - Order and print out a new member identification (ID) card if you lose yours,
   - Check the status of a claim
   - Find out how much a service costs
   - Search for a doctor, specialty, hospital or other health care professional
   - Learn about hundreds of health and wellness topics
   - And much more
4. **Finding an in-network doctor, specialist, hospital or a list of your medicines is a snap.** Just go our website and search the Online Provider Directory. Or call the Customer Service number on your member ID card. A customer service representative can give you information by phone, e-mail, fax or mail.

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 user name and password

Then you're ready to go!

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Your guide to Anthem Blue Cross Blue Shield benefits (continued)

We're on Facebook, Twitter and YouTube.

Did you know, that when you take better care of yourself, those around you will, too? Your health influences family, friends, even neighbors. (Studies prove it.) We're committed to helping you improve your health, wherever you go. And since you connect with friends, family, and coworkers – night and day, we've made it easy for you to connect with us.

Connect with Bob Harper from the television show *The Biggest Loser*.

We've teamed up with Bob Harper from the television show The Biggest Loser. Join us on the sites below for health, wellness and motivational ideas.

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

At healthychat.com you can chat one-on-one about health care.

There's been a lot of talk about how health care is changing and how those changes impact every one of us. Join our conversations on this interactive website and learn about health care reform and health insurance

Please take a few minutes to look over the information in this booklet. And keep it handy for the future. If you have any questions, just ask your benefits manager. And thanks for considering us.

Table of Contents

Page

Your Health Benefits

Blue Access® PPO

Blue Access is a PPO plan that gives you unlimited flexibility over which physicians you use.

Blue Access provides benefits for covered services provided by non-network physicians and hospitals. However, if you decide to use providers that are in Anthem's network, you can enjoy a lower out-of-pocket expense. Please refer to your benefit summary page for details on how Anthem's Blue Access product can work for you.

Get More for Your Health Benefit Dollar

Blue Access gives you freedom of choice because you can use network or non-network providers. However, working with network providers can offer you more effective health care coordination, potential cost savings and less paperwork hassle.

No Referral Necessary When You Use Anthem's Networks

When you use non-network providers, it is necessary to call Anthem for precertification prior to your visit (one exception is emergency care) in order to avoid paying more.

Extensive Networks Make Finding Care Easy — Even While Traveling

BlueCard®

With Blue Access, you have access to scheduled doctor appointments, preventive care benefits, and emergency and urgent care visits — even while traveling. That's because the BlueCard program links participating providers to Blue Cross and Blue Shield licensees across the country. More than 85 percent of all U.S. physicians and hospitals contract with Blue Cross and Blue Shield licensees.[1] So whether you're traveling on business or pleasure, on a weekend getaway or an extended stay, you have flexible easy-to-use coverage.

- ***By choosing a participating BlueCard PPO provider, you receive the highest benefit level.***
- ***By choosing a non-participating BlueCard PPO provider, you receive a reduced benefit level and you may be subject to balance billing.***

Blue Access® PPO (cont.)

How to access coverage while traveling

1. ***Find a doctor or hospital. To find the nearest provider, go to* anthem.com*, call BlueCard Access at* (800) 810-BLUE (2583)*, or call the customer service number on the back of your ID card.***
2. ***Contact Anthem. Call customer service to verify coverage. Then, call the precertification number to receive prior approval for certain services. Both numbers can be found on the back of your ID card.***
3. ***Visit the provider and present your ID card. The provider will verify benefits and eligibility.***
4. ***Allow the network provider to file your claim. After you receive care, the provider will electronically file the claim. You are responsible only for normal out-of-pocket expenses, such as a copayment, deductible or non-covered service.***
5. ***Look for an explanation in the mail. Anthem processes the claim, reimburses the provider if necessary and mails you an explanation of benefits (EOB).***

Of course, in case of an emergency, bypass these steps and go to the nearest health care facility.

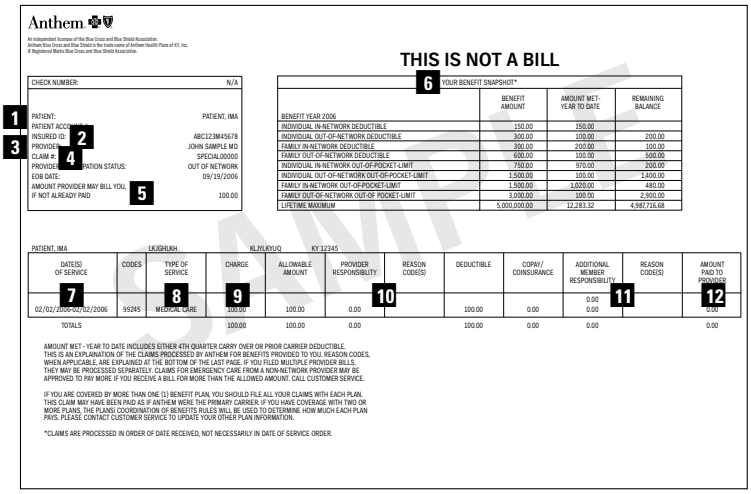
1 Blue Cross and Blue Shield Association, www.bcbs.com/employers/index.html, Aug. 26, 2004.

How to understand your Explanation of Benefits (EOB)

Get the most from your benefits by keeping up to date on your claims

We will send you an Explanation of Benefits (EOB) when a health care provider (doctor, specialist, hospital, lab, facility or other health care professional) files a claim for your care. An EOB is not a bill, but it can help you figure out if you need to pay anything to your health care provider (see number five below). You may not always receive a hard copy EOB in the mail. For example, if you only need to pay a copay for a doctor visit or other service, we will not mail you an EOB. However, you can still view your medical EOBs/claims recaps online at anthem.com. You can even choose to go completely paperless for all medical EOBs/claims recap statements by selecting "Go Paperless" in your account profile.

Here is a sample of an EOB with some of the key parts and what they mean:



Anthem

THIS IS NOT A BILL

CHECK NUMBER: N/A

PATIENT: PATIENT, IMA
PATIENT ACCOUNT #:
INSURED ID: ABC123M45678
PROVIDER: JOHN SAMPLE MD
CLAIM #: SPECIAL00000
PROVIDER PARTICIPATION STATUS: OUT OF NETWORK
EOB DATE: 09/19/2006
AMOUNT PROVIDER MAY BILL YOU, IF NOT ALREADY PAID: 100.00

YOUR BENEFIT SNAPSHOT*

BENEFIT YEAR 2006	BENEFIT AMOUNT	AMOUNT MET-YEAR TO DATE	REMAINING BALANCE
INDIVIDUAL IN-NETWORK DEDUCTIBLE	150.00	150.00	
INDIVIDUAL OUT-OF-NETWORK DEDUCTIBLE	300.00	100.00	200.00
FAMILY IN-NETWORK DEDUCTIBLE	300.00	200.00	100.00
FAMILY OUT-OF-NETWORK DEDUCTIBLE	600.00	100.00	500.00
INDIVIDUAL IN-NETWORK OUT-OF-POCKET-LIMIT	750.00	970.00	200.00
INDIVIDUAL OUT-OF-NETWORK OUT-OF-POCKET-LIMIT	1,500.00	100.00	1,400.00
FAMILY IN-NETWORK OUT-OF-POCKET-LIMIT	1,500.00	1,020.00	480.00
FAMILY OUT-OF-NETWORK OUT-OF POCKET-LIMIT	3,000.00	100.00	2,900.00
LIFETIME MAXIMUM	5,000,000.00	12,283.32	4,987,716.68

PATIENT, IMA LKJGHLKJH KLJYLKYUQ KY 12345

DATE(S) OF SERVICE	CODES	TYPE OF SERVICE	CHARGE	ALLOWABLE AMOUNT	PROVIDER RESPONSIBILITY	REASON CODE(S)	DEDUCTIBLE	COPAY / COINSURANCE	ADDITIONAL MEMBER RESPONSIBILITY	REASON CODE(S)	AMOUNT PAID TO PROVIDER
02/02/2006-02/02/2006	99245	MEDICAL CARE	100.00	100.00	0.00		100.00	0.00	0.00 0.00		0.00
TOTALS			100.00	100.00	0.00		100.00	0.00	0.00		0.00

AMOUNT MET - YEAR TO DATE INCLUDES EITHER 4TH QUARTER CARRY OVER OR PRIOR CARRIER DEDUCTIBLE.
THIS IS AN EXPLANATION OF THE CLAIMS PROCESSED BY ANTHEM FOR BENEFITS PROVIDED TO YOU. REASON CODES, WHEN APPLICABLE, ARE EXPLAINED AT THE BOTTOM OF THE LAST PAGE. IF YOU FILED MULTIPLE PROVIDER BILLS, THEY MAY BE PROCESSED SEPARATELY. CLAIMS FOR EMERGENCY CARE FROM A NON-NETWORK PROVIDER MAY BE APPROVED TO PAY MORE IF YOU RECEIVE A BILL FOR MORE THAN THE ALLOWED AMOUNT. CALL CUSTOMER SERVICE.

IF YOU ARE COVERED BY MORE THAN ONE (1) BENEFIT PLAN, YOU SHOULD FILE ALL YOUR CLAIMS WITH EACH PLAN. THIS CLAIM MAY HAVE BEEN PAID AS IF ANTHEM WERE THE PRIMARY CARRIER. IF YOU HAVE COVERAGE WITH TWO OR MORE PLANS, THE PLANS' COORDINATION OF BENEFITS RULES WILL BE USED TO DETERMINE HOW MUCH EACH PLAN PAYS. PLEASE CONTACT CUSTOMER SERVICE TO UPDATE YOUR OTHER PLAN INFORMATION.

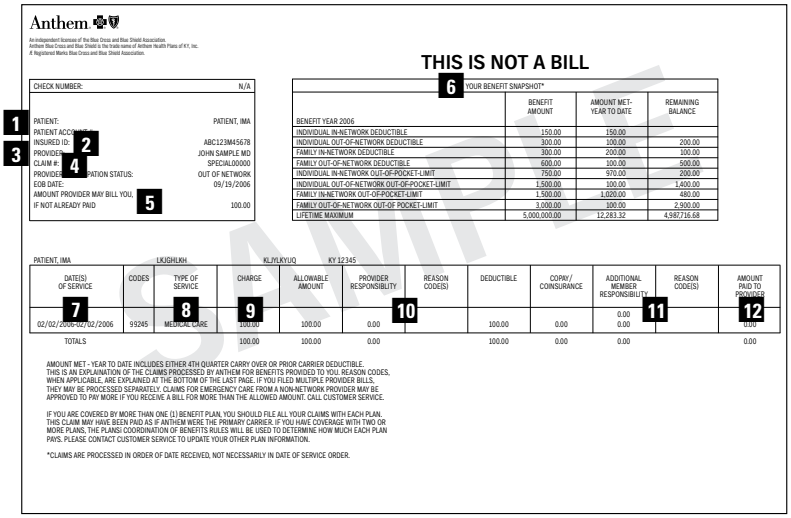
*CLAIMS ARE PROCESSED IN ORDER OF DATE RECEIVED, NOT NECESSARILY IN DATE OF SERVICE ORDER.

SAMPLE

1. **Patient:** The person who received care.
2. **Insured ID:** This is the identification (ID) number of the subscriber, who is the employee covered by Anthem Blue Cross and Blue Shield (Anthem). This number is also on your Anthem ID card. Please give us this number if you call or write with questions.
3. **Provider:** A doctor, specialist, hospital, lab, facility or other health care professional who provided services for the patient. The provider name shown may be different than your provider's name because services such as tests, X-rays and visits may be provided by other health care professionals or facilities if your doctor uses them.
4. **Claim #:** This is the number that refers to the claim. You should have this number handy when calling Customer Service.
5. **Amount Provider May Bill You, If Not Already Paid:** This is how much you owe to the provider.
6. **Your Benefit Snapshot:** This gives you an overview of benefits, including how much you have paid so far for your deductible (the amount you pay for services before Anthem starts paying for your care). **Note:** For more information on your benefits, call Customer Service or see your Certificate.
7. **Dates of Service:** This is when you got care.
8. **Type of Service:** A description of each service listed in the claim.
9. **Charge:** This is how much the provider billed for each service. **Note:** If the charges include Medicare or Complementary services, this is the amount billed to Medicare.

How to understand your Explanation of Benefits (EOB)

10. **Provider Responsibility and Reason Code(s):** A provider in our network agrees to accept a certain amount for services as payment in full. If the provider charges more for a service, the provider is responsible for the difference, and the member does not have to pay this amount. This is in addition to any Anthem discounts that may apply to the claim. The codes shown in the column to the right refer to notes about each claim. These notes explain the provider's responsibility.
11. **Additional Member Responsibility and Reason Code(s):** This is how much you owe to the provider, plus any deductible, coinsurance or copays that may apply to this claim. The codes shown to the right refer to notes about each claim. These notes explain what you owe and why you may be responsible for paying for a service.
12. **Note:** This column may read **Amount Paid to Provider, Amount Paid to Member or Amount Paid to Alternate** (for example, Custodial Parent) depending on who is receiving payment for the claim.



Anthem

An independent licensee of the Blue Cross and Blue Shield Association.
Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of KY, Inc.
® Registered Marks Blue Cross and Blue Shield Association.

THIS IS NOT A BILL

CHECK NUMBER: N/A

1 PATIENT: PATIENT, IMA
PATIENT ACCT #:
3 INSURED ID: 2 ABC123M45678
PROVIDER: JOHN SAMPLE MD
4 CLAIM #: SPECIAL00000
PROVIDER PARTICIPATION STATUS: OUT OF NETWORK
EOB DATE: 09/19/2006
AMOUNT PROVIDER MAY BILL YOU. 5
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6 YOUR BENEFIT SNAPSHOT*

	BENEFIT AMOUNT	AMOUNT MET-YEAR TO DATE	REMAINING BALANCE
BENEFIT YEAR 2006			
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INDIVIDUAL OUT-OF-NETWORK DEDUCTIBLE	300.00	100.00	200.00
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LIFETIME MAXIMUM	5,000,000.00	12,283.32	4,987716.68

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DATE(S) OF SERVICE	CODES	TYPE OF SERVICE	CHARGE	ALLOWABLE AMOUNT	PROVIDER RESPONSIBILITY	REASON CODE(S)	DEDUCTIBLE	COPAY/ COINSURANCE	ADDITIONAL MEMBER RESPONSIBILITY	REASON CODE(S)	AMOUNT PAID TO PROVIDER
7		8	9		10				11		12
02/02/2006-02/02/2006	99245	MEDICAL CARE	100.00	100.00	0.00		100.00	0.00	0.00		0.00
TOTALS			100.00	100.00	0.00		100.00	0.00	0.00		0.00

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*CLAIMS ARE PROCESSED IN ORDER OF DATE RECEIVED, NOT NECESSARILY IN DATE OF SERVICE ORDER.

SAMPLE

Did you know that you can get your medical EOBs online? Here's how.

- Log in to anthem.com (if you haven't registered yet, you will need to register to log in).
- Click on "Profile."
- Scroll down the page to choose how you would like to receive your medical EOBs/claims recaps and select "Go Paperless."*

*Only the subscriber can pick this option.

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.

Take care of yourself. Use your preventive care benefits.

Getting regular checkups and exams can help you stay well, catch problems early and may be lifesaving. Our health plans cover 100% of the services listed in this flier as preventive care.[1] This follows the health care reform law and state regulations. When you get these services from providers in the network, you don't have to worry about paying anything out of your own pocket for covered preventive care such as screenings, immunizations and exams. You may have to pay part of the costs if you use a provider outside the network.

Here's an overview of the types of preventive services we cover. Refer to your benefits summary to learn more.

Preventive versus diagnostic care

What's the difference? Preventive care is precautionary. Diagnostic care is used to find the cause of existing symptoms. For example, if your doctor suggests you have a colonoscopy because of your age, that's preventive care. But, if 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 (this is your "cost share").

Child preventive care (birth to 18 years)

Preventive care physical exams are covered as well as the screenings, tests and vaccines listed here. The preventive care services listed below may not be right for every person. Please ask your health care provider what's right for you.

Preventive physical exams

Age-appropriate screening tests may include:

- Newborn screenings
- Vision screening[2]
- Hearing screening
- Developmental and behavioral assessments
- Oral health assessment
- Screening for lead exposure
- Hemoglobin or hematocrit (blood count)
- Blood pressure
- Height, weight and body mass index (BMI)
- Cholesterol and lipid level screening
- Screening for depression
- Screening and counseling for obesity
- Behavioral counseling to promote a healthy diet
- Screening for sexually transmitted infections
- Pelvic exam and Pap test, including screening for cervical cancer

Immunizations:

- Hepatitis A
- Hepatitis B
- Diphtheria, Tetanus, Pertussis
- Varicella (chicken pox)
- Influenza (flu)
- Pneumococcal (pneumonia)
- Human Papillomavirus (HPV)
- Haemophilus Influenza type b (Hib)
- Polio
- Measles, Mumps, Rubella (MMR)
- Meningococcal (meningitis)
- Rotavirus

20619ANMENABS 4/11

Take care of yourself. Use your preventive care benefits. (continued)

Adult preventive care (19 years and older)

Preventive care physical exams are covered as well as the screenings, tests and vaccines listed here. The preventive care services listed below may not be right for every person. Please ask your health care provider what's right for you.

Preventive physical exams

Age-appropriate screening tests may include:

- Eye chart vision screening[2]
- Hearing screening
- Cholesterol and lipid level screening
- Blood pressure
- Height, weight and BMI
- Screening for depression
- Diabetes screening
- Prostate cancer screening including digital rectal exam and PSA test
- Breast cancer screening, including exam and mammography
- Pelvic exam and Pap test, including screening for cervical cancer
- Screening for sexually transmitted infections
- HIV screening
- Bone density test to screen for osteoporosis
- Colorectal cancer screening including fecal occult blood test, barium enema, flexible sigmoidoscopy, screening colonoscopy and CT colonography (as appropriate)
- Aortic aneurysm screening (men)
- Screenings during pregnancy (including but not limited to, hepatitis, asymptomatic bacteriuria, Rh incompatibility, syphilis, iron deficiency anemia, gonorrhea, chlamydia and HIV)
- Intervention services (includes counseling and education):
  - Screening and counseling for obesity
  - Genetic counseling for women with a family history of breast and/or ovarian cancer
  - Behavioral counseling to promote a healthy diet
  - Primary care intervention to promote breastfeeding
  - Counseling related to aspirin use for the prevention of cardiovascular disease (does not include coverage for aspirin)
  - Screening and behavioral counseling related to tobacco use
  - Screening and behavioral counseling related to alcohol misuse

Immunizations:

- Hepatitis A
- Hepatitis B
- Diphtheria, tetanus, pertussis
- Varicella (chicken pox)
- Influenza (flu)
- Pneumococcal (pneumonia)
- Human Papillomavirus (HPV)
- Measles, Mumps, Rubella (MMR)
- Meningococcal (meningitis)
- 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 Preventive care services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits
2 Some plans cover additional vision services. Please see your contract or Certificate of Coverage for details.

20619ANMENABS 4/11

Your prescription drug plan

Retail pharmacy network

Our network includes more than 64,000 pharmacies across the country. That means you have easy access to your prescriptions wherever you are – at work, home or even on vacation. Using pharmacies in the network will help you get the most from your drug plan. When picking up your prescription at the pharmacy, be sure to show your plan ID card.

To make sure your pharmacy's in our network, visit **anthem.com**.

- Log in and click on "Refill a Prescription." You will be directed to the Express Scripts website.
- Click on "My Prescription Plan" in the left-hand column.
- Click on "Find a Pharmacy."

Choosing a non-network pharmacy means you'll pay the full cost of your drug. Then, you may submit a claim form to be repaid. To access the form, visit **anthem.com**.

- Log in and select the "Refill a Prescription" link. You will be directed to the Express Scripts website.
- Click on "My Prescription Plan" in the left-hand column, then click on "Coverage & Copayments." The claim form is on this page.

Home Delivery Pharmacy

Home delivery is for people who take medicine on an ongoing basis. Our preferred Home Delivery Pharmacy, managed by Express Scripts, sends you the medicine you need, right to your door. As a home delivery customer, you'll also enjoy:

- Free standard shipping
- Access to pharmacists for drug questions
- Safe, accurate prescriptions

Note about your pharmacy information on the web:

Express Scripts is the company that manages the operations of your drug plan. The first time you're directed to the Express Scripts website, you'll go through a brief registration. The purpose is to set your preferences for communication and privacy. You'll do this only once.

Please do not go directly to the Express Scripts website. The only way to make sure you're viewing your pharmacy information correctly is by logging in to **anthem.com** first.

13127INMENABS 3/11

Your prescription drug plan (continued)

Getting started with home delivery

Switching is simple. You can order by phone, mail or fax.

By phone: Call **866-216-4207**, Monday through Friday, 8:30 a.m. to 8 p.m., Eastern time. You'll find out how much your prescription will cost and how much you can save. Have this information handy: your prescription, doctor's name, phone number, drug names and strengths and credit card (cardholder name, account number and expiration date).

By mail: Visit **anthem.com** to get an order form.

- Log in and select "Refill a Prescription." You will be directed to the Express Scripts website.
- Click on "Fill a New Prescription."
- Choose the "Print a Prescription Order Form" link. You can print the form and complete it by hand. Or you can fill out a web-based form and print it.
- Mail your completed form, prescription from your doctor, and payment to:

  Home Delivery Pharmacy
  PO Box 66584
  St. Louis, MO 63166-6584

By fax: Have your doctor fax your prescription to **800-875-6356**. It must be faxed directly from your doctor's office. If there is a question about your prescription, the pharmacy will contact your doctor.

Ordering refills

With home delivery, you don't have to worry about running out of medicine. That's because the pharmacy will let you know when it's time to order refills. You can easily order by phone, mail or online.

By phone: Have your prescription label and credit card ready. Call **866-216-4207** and select "Automated Refill Order Line" from the menu. Or press zero any time to speak with a patient care advocate. If you are speech or hearing impaired, call **800-899-2114**. Follow the prompts to place your order.

By mail: Fill out an order form you received with a previous order. Affix your label or write your refill number in the space provided. Mail the form and your payment to:

Home Delivery Pharmacy
PO Box 66584
St. Louis, MO 63166-6584

13127INMENABS 3/11

Your prescription drug plan (continued)

Online: Visit **anthem.com**.

- Log in and select "Refill a Prescription." You will be directed to the Express Scripts website.
- Choose the drugs you want to refill, and click "Add Refills to Cart."
- Review the order, shipping method, payment, medical information and contact information, and make changes if needed.
- Click "Place My Order."

Specialty pharmacy

CuraScript, the Express Scripts specialty pharmacy, provides support and medicine for people with complex, long-term conditions. They include (but aren't limited to):

- Asthma
- Cancer
- Crohn's Disease
- Gaucher's Disease
- Hemophilia
- Hepatitis C
- HIV/AIDS
- Infertility
- Multiple sclerosis
- Primary immune deficiency
- Psoriasis
- Pulmonary arterial hypertension
- Rheumatoid arthritis
- Respiratory syncytial virus (RSV)
- Transplant

Nurses, pharmacists and patient care advocates work together to help improve your care. Their goal is to help you get the best results from your treatments.

Ordering specialty drugs

You can place your first order by phone or fax.

By phone: Call **800-870-6419**, Monday through Friday, 8 a.m. to 10 p.m., Eastern time. A patient care advocate will help you get started.

By fax: Ask your doctor to fax your prescription and a copy of your plan ID card to **800-824-2642**.

13127INMENABS 3/11

Your prescription drug plan (continued)

Ordering refills

Online: Visit **anthem.com**.

- Log in and select "Refill a Prescription." You will be directed to the Express Scripts website.
- Choose the drugs you want to refill, and click "Add Refills to Cart."
- Review the order, shipping method, payment, medical information and contact information, and make changes if needed.
- Click "Place My Order."

Note: For some drugs, you must call to order a refill.

By phone: Have your member ID number and CuraScript prescription number ready. Call **800-870-6419** and select "Place a Refill Order" from the menu. Or press zero any time to speak with a patient care advocate. If you are speech or hearing impaired, call **800-221-6915**. Follow the prompts to place your order.

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 and generic drugs.

We research drugs and select ones that are safe, work well and offer the best value. That's because we think it's important to cover drugs that help people stay healthy so they can work, go to school, and continue the activities of a busy life.

Sometimes we update the Drug List if new drugs come to market, or if new research becomes available. To view the current list, visit **anthem.com**. Click on "Customer Care" in the top-right corner. Select your state, then click "Download Forms." You'll find the Drug List on this page.

If you don't have access to a computer, you can check the status of a drug by calling Customer Service at the phone number on your plan ID card.

Generic drugs

Your plan covers brand and generic (or non-brand) drugs. When you choose a generic, you'll get the same effect as a brand drug – but usually at a lower cost.

Brand and generic drugs have the same active ingredient, strength and dose. And, generics must meet the same high standards for safety, quality and purity.

13127INMENABS 3/11

Your prescription drug plan (continued)

Why generics cost less

Developing a new drug is expensive. When a company creates a new drug, it gets a patent for up to 20 years. That means only the company that created it can sell it during that time. Once the patent expires, other companies can make copies of the same drug. These companies can avoid the high costs of developing the drug – and that helps lower the price for you.

Talk to your doctor to see if a generic is right for you. Don't switch or stop taking any drugs until you talk to your doctor.

Prior authorization

Most prescriptions are filled right away when you take them to the pharmacy. But, some drugs need our review and approval before they're covered. This process is called prior authorization. It focuses on drugs that may have:

- Risk of serious side effects
- High potential for incorrect use or abuse
- Better options that may cost you less
- Rules for use with very specific conditions

If your drug needs approval, your pharmacist will let you know. To check in advance, call the Customer Service phone number on your ID plan card.

The Drug List also includes this information. To view it, visit **anthem.com**. Click on "Customer Care" in the top-right corner. Select your state, then click on "Download Forms." You'll find the Drug List on this page.

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 66584
   St. Louis MO 63166-6584

To FAX your prescription:
1. Both "Dr/Prescriber" and "Rx Form" boxes must be filled out.
2. Doctor can fax to: 1-800-875-6356
   - **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.

Important Confidentiality Notice: This and any documents accompanying this transmission may contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.

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Health, Wellness & Anthem Advantages

Get the most out of your health plan

anthem.com

Clear. Intuitive. Easy.

Save money and live better with tools that keep you informed, in control, and at your healthy best.

Health and wellness

Now it's easier than ever to improve your health and well-being. Simply log in at anthem.com. You have access to an array of innovative tools to help you manage your health and achieve your goals.

Not registered at anthem.com?
Sign up now for access to personalized service and resources. It's fast, easy and secure..

360° Health® programs

The programs you read about here come with your health plan. There is no extra cost for them.

To learn more about these programs online, log in to anthem.com and click on "Health and Wellness".

Take charge of your health and the choices you make

We all have different health needs. Maybe you're fit and want to stay that way. Maybe you're living with a chronic condition like asthma. Or maybe you fall somewhere in between. No matter where you fall, our 360° Health program is here to give you all the help you need to live healthier. From tips and tools you can find online to nurses you can talk to on the phone, 360° Health can help you take better control over your health. And it can give you the power to make the decisions that are right for you.

ComplexCare

ComplexCare is for our members with more than one health problem or a condition that puts them at risk for needing more care, more often. If you sign up for ComplexCare, you, your family and your doctors will work with a ComplexCare nurse and others on our staff. They'll help you meet health goals and help you avoid going in and out of the hospital.

With ComplexCare, you have 24/7 toll-free access to nurses who will work one-on-one with you to teach you about taking care of your condition while living the life you like to live. They'll also help you learn about why it's important to go for regular checkups and screenings. The nurses can help you make better choices about your care. They can also help make sure your doctors are all talking to each other about your care and what's best for you. If you qualify for the ComplexCare program, a nurse will contact you.

To learn more, log on to anthem.com or contact the customer service number on your ID card.

Information You Should Know

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

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

Utilization Management

Utilization Management (UM) is a program that is part of your health plan that lets us make sure you're getting the right care at the right time. Our UM program is made up of a team of licensed health care professionals such as nurses and doctors who do medical reviews. The UM review team goes over the information we have received from your doctor or other health care provider to see if a surgery, treatment or other type of care that has been requested is medically needed. The UM review team checks to make sure that the treatment meets specific rules set by your health plan. After reviewing the records and information, the surgery or treatment will be approved (covered) or denied (not covered) and the UM review team will let you and your doctor know as soon as possible.

Medical reviews like this can be done 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 medical care is given)
A prospective review is done before a member goes to the hospital or has some other type of service or treatment.

Here are some types of medical needs members may have that might call for a prospective review:

- To go to (and/or stay at) a hospital
- An outpatient procedure (the member can go home the same day)
- Tests done to try to find the cause of an illness such as MRI (Magnetic Resonance Imaging) and CT (Computed Tomography) scans
- A certain type of outpatient therapy such as physical therapy or emotional health counseling
- "Durable medical equipment" (DME) which means wheelchairs, walkers, crutches, hospital beds and more

The concurrent review (done during medical care and recovery)
A concurrent review is done at the time the member is in the hospital or is released and needs more care related to the hospital stay. This could mean services or treatment done in a doctor's office, regular office visits, physical or emotional therapy, home health care, durable medical equipment (see above), staying in a nursing home, getting emotional health care 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 a specific medical treatment

The retrospective or post-service review (done after medical care is given)
A retrospective review is done when a member has already had surgery or another type of medical care. When the UM review team becomes aware of the treatment, they will look at the member's medical information that the doctor or provider had at the time the medical care was given. They can then 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, and help you better understand your health benefits.

Your rights and responsibilities as an Anthem Blue Cross Blue Shield member

As Anthem Blue Cross Blue Shield Anthem Blue Cross Blue Shield (Anthem) 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.

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.

20008ANMENABS 5/11

Your rights and responsibilities as an Anthem Blue Cross Blue Shield member (continued)

- 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".

20008ANMENABS 5/11

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 co-insurance.

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

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 job. 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 judgements 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.

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.

Health care reform and your plan

What's changing and when?

You've probably heard a lot of people talk about health care reform lately. But you may have questions about what it all means for you and your family – questions that even your news junkie neighbor can't answer.

JOIN IN.

To share your thoughts and ask questions about health care reform, visit healthychat.com.

Here's a quick summary of how the new law may affect your group health plan within the next year. Keep in mind that other employers' plans may have different rules. If you have questions about your specific benefits, call the customer service number on your member ID card or contact your group benefits administrator for a number to call.

When you enroll:

You'll have a chance to add young adult dependents to your plan

The federal health care reform law allows children to stay on their parent's or guardian's health plan until their 26th birthday. In some states, dependents can stay on the plan even longer. To be eligible for this coverage, children do not need to be financially dependent on you for support, claimed as dependents on your tax return, residents of your household, enrolled as students or unmarried. If you have dependents younger than 26 who aren't on your plan now, you can add them to your plan during your next open enrollment. If your plan already covers dependents up to age 26, you don't have to do anything. They'll stay on your plan automatically.

After your plan's effective date:

Kids under 19 can get coverage even if they have health conditions

The law says group health plans and insurers can't have pre-existing condition exclusions for children under the age of 19. Healthcare.gov, a website run by the federal government, defines a pre-existing condition as "a condition, disability or illness (either physical or mental) that you have before you enrolled in a health plan." Very few group health plans deny coverage altogether because of pre-existing conditions. However, some plans still have waiting periods for members who have pre-existing conditions. A waiting period means certain benefits aren't available right away.

You may have more flexibility in choosing doctors

This part of the law applies to you only if your plan requires you to select a primary care provider (PCP) and get referrals from your PCP to see a specialist. If you have this type of plan, you'll have the right to choose any primary care provider as your PCP, as long as the provider is in our network and will accept you or your family members. If your plan covers children, you may choose a pediatrician as their primary care provider. Also, you don't need prior approval from the plan or a referral from your primary care provider to get obstetrical or gynecological care from an in-network OB-GYN.

17076ANMENABS 10/10

Health care reform and your plan (continued)

Your plan's dollar limits may change

In the past, plans could have a "lifetime maximum" – a dollar limit on what the plan will pay for health care services over your lifetime. If your plan had a lifetime maximum, it's gone now. However, you should know that other limits may still apply. For example, you may have limits on certain services that aren't considered "essential health benefits." Also, you may have limits on how many times you can use a benefit during the year.

WHAT'S NEXT?

We don't want to overwhelm you, so this list only includes changes that may affect you within the next year. Other changes will take place through 2018, such as:

- **Guaranteed coverage for people of all ages – not just children – regardless of their health**
- **Health insurance exchanges where people who buy individual coverage and people who work for small businesses can shop for a plan**
- **Information on your W-2 tax statement about how much your employer paid for your health plan**
- **Changes to make health care more affordable for people who have Medicare**

If you want to know more, you can get the latest information about health care reform at healthychat.com.

17076ANMENABS 10/10

If you have a medical condition before joining our plan you may have to wait for coverage

Your Anthem Blue Cross Blue Shield (Anthem) health plan has a pre-existing condition exclusion. This means that if you have a medical condition that was diagnosed before coming to our plan, you might have to wait 12 months before your plan will pay for health care services related to that issue.

What are examples of pre-existing conditions?

- Health issues like asthma, heart disease, diabetes, etc.
- Health issues that a doctor told you that you have within the last six months.
- Health issues you have had health care treatment for in the last six months.

Waiting periods

There are two types of waiting periods:

- **If you didn't have health coverage before** coming to Anthem you may have to wait the whole 12 months.
- **If you did have health coverage before** coming to Anthem you may not have to wait. It depends on what type of coverage you had. If it has been less than 63 days since you had health coverage before starting with Anthem, you may be able to cut down your 12-month waiting period by the number of days you had coverage.

Note: If your employer requires a waiting period, you cannot have had a doctor diagnose a pre-existing condition on or before the day your waiting period begins.

So for example – if your waiting period on your new job begins on October 1 – any condition that's been diagnosed or treated for the six months up until September 30 would be considered a pre-existing condition. So you would have to be in a waiting period for coverage.

Other exceptions include:

- Being pregnant – you will not have to wait if you are pregnant
- If you are under age 19
- A child or children who are signed up for coverage within 31 days after birth, adoption or placement for adoption

02178ANMENABS 5/11

If you have a medical condition before joining our plan you may have to wait for coverage (continued)

If you had recent health coverage, follow these steps to show proof of that coverage.

- Check your last ID card from the company you had health coverage with to get the phone number or address.
- If your coverage was through your last job and you don't know how to reach the insurance company that covered you before, call the Human Resources phone number where you used to work.
- Check if you have a health plan booklet or other information about your coverage from that company. You may be able to find a phone number there. You can always call Anthem for help on how to do this.
- Once you have the contact information for the company that you had health coverage with, contact them.
- Ask them how to get a "certificate of creditable coverage" or other proof that you had health coverage with them.
- Once you get your "certificate of creditable coverage" from them, send it to our address on the back of your new Anthem ID card.

Need help?

We're here for you. Call us at the phone number on the back of your Anthem ID card if you have questions about coverage for pre-existing conditions. If you don't have your ID card yet, contact your human resources department for the phone number.

02178ANMENABS 5/11

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

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

Anthem®

Health. **Join In.**℠

An employer may elect to insure or self-fund its group health plan. For self-funded accounts, Anthem Blue Cross and Blue Shield provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims. In Ohio, if your employer selects Blue Preferred Primary and elects to insure its group health plan, Blue Preferred Primary is a health insuring corporation product ("HIC"); if your employer selects Blue Preferred Primary and elects to self-fund its group health plan, Anthem provides access to the Blue Preferred Primary network, provides administrative claims payment services only and assumes no financial risk for claims. Please consult your employer for plan funding details.

The benefit descriptions in this plan overview are intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract and are subject to your employer's plan funding arrangement. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

Life and disability products are underwritten by Anthem Life Insurance Company. Anthem Blue Cross and Blue Shield is the trade name of: In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Ohio: Community Insurance Company. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWi), which underwrites or administers the PPO and indemnity policies; Compcare Health Services Insurance Corporation (Compcare), which underwrites or administers the HMO policies; and Compcare and BCBSWi collectively, which underwrite or administer the POS policies. Independent licensees of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are the registered marks of the Blue Cross and Blue Shield Association.

Express Scripts, Inc. is a separate company that provides pharmacy services and pharmacy benefit management services on behalf of health plan members.

The Healthy Lifestyles programs are administered by Healthways, Inc., an independent company.