Anthem BlueCross BlueShield

Ready to choose your benefits?

We can point you in the right direction.

City of Norwich

This guide is information only. You must enroll to be covered.

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Anthem BlueCross BlueShield

An Anthem Blue Cross and Blue Shield ID card means something

It means you have access to quality care from quality doctors. It means you can always get your questions answered. It means you have our support before you ever need health care. And that's what this guide is for. We want you to have everything you need to make a good decision.

Choose a health plan that works for you

Visit anthem.com/basics to learn more.

HMO

This plan covers services from doctors in your plan. You'll need to choose a main doctor, also called a primary care doctor, from the **Health Maintenance Organization** (HMO) plan. If you need a specialist, you'll most likely have to go through your primary care doctor to get a referral.

Some HMO plans may have different rules. So be sure to check your plan details.

PPO

This plan covers services from almost any doctor or hospital, but you get a discount if you use a doctor from the **Preferred Provider Organization** (PPO) plan. You pay more if you go to a doctor who's not in the PPO plan. You don't usually need a referral from your main doctor, also called a primary care doctor, to see a specialist.

Some PPO plans may have different rules. So be sure to check your plan details.

HSA

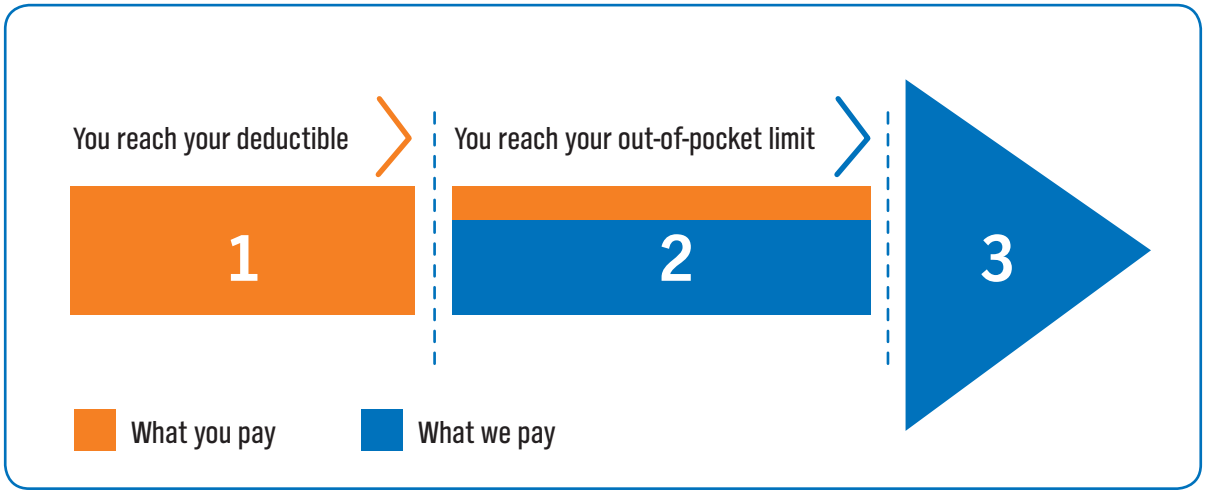
This plan comes with a **Health Savings Account** (HSA) you can use to pay your deductible or save for future health care costs. Once you pay your deductible, you'll pay a percentage of the total cost, and your plan will cover the rest.

HSA contributions are tax-free. If you don't use all the money in your HSA, your money will roll over to the next year. And you can take the money in your HSA with you if you leave your employer or change health plans.

The doctors, hospitals and other health care providers in your plan have agreed to charge lower rates for our members.

Getting started with health insurance

When you visit your doctor, it's important to understand how your health plan works.



1. **You pay your deductible.** This is a set amount that you pay before we share the cost for covered health care. If your plan has **copays** (flat fees like $30 for each visit) along with a deductible, you only need to pay the copay for most doctor visits. If you choose a plan with a Health Savings Account, you can use the money in your account to pay towards your deductible.
2. **After you meet your deductible, you'll only pay part of the cost.** You pay a copay or a percentage of the cost, also called coinsurance, each time you get care. Your plan covers the rest.
3. **You're protected by your plan's out-of pocket limit.** That's the most you pay for covered health services each year. With some plans, you still have copays even after you reach your out-of-pocket limit.
   - What about the money for your health plan that gets deducted from your paycheck? That's the payment for your plan. Think of it like a membership fee. It's separate from what you pay when you get care.
   - Remember, this chart is only an example. Your actual costs will depend on the type of plan you choose, the service you get and the doctor. To see your actual costs, please refer to your plan information.

You can register at anthem.com or on the mobile app — your simple and convenient solution to managing your health.

Frequently asked questions (FAQ)

Can I keep my current doctor?

Yes, you can. But keep in mind that you get the most out of your benefits if you choose a doctor in your plan. Some plans cover only services from doctors in your plan, which means you pay for the full cost if you see a doctor outside of the plan. Other plans cover services from doctors outside the plan — but your plan pays more of the cost when you see a doctor in your plan. Be sure to check the details of your plan.

To find out if your doctor is in the plan, or to find a new doctor in the plan, go to our *Find a Doctor* tool on anthem.com. You can search by specialty and check a doctor's training, certifications and member reviews. Be ready to enter your plan name to view the doctors that serve your plan. You can also use *Find a Doctor* on your smartphone.

How do I use my health plan when I need care?

After you enroll, your member ID card will come in the mail. Be sure to bring it with you to the doctor. You can also show a copy of your ID card from the Anthem mobile app.

Is preventive care covered?

Yes, preventive care from a doctor in the plan is covered at 100%. It's very important to take care of your health with regular checkups even when you feel fine. So talk to your doctor about screenings and immunizations that you may need to protect your health.

Can I manage my plan and health care on anthem.com?

Yes. As soon as you become a member, you'll be able to register at anthem.com or on the Anthem mobile app. It's designed to help you manage your health care and your benefits simply and conveniently. Many of our members find these self-service tools helpful:

- Check on your claims.
- Find a doctor.
- Track your health care spending.
- Compare quality and costs at hospitals and other facilities.
- View your health account balance and claims

Visit **anthem.com/guidedtour** to watch a video explaining how our website can help you.

How can Anthem help me save money?

You'll save money every time you go to a doctor in your plan – they've agreed to charge lower rates for Anthem members. But we'll also help save you money before you go to the doctor.

At anthem.com, you can compare how much a medical procedure will cost at different locations. Plus, all members get discounts on health-related products. You can even print your own coupons for healthier groceries.

Your plan details

In this next section, you'll find more information about your plan.

BLUECARE POE
$10/$0/$50/$0
CITY OF NORWICH

BlueCare is a health maintenance organization (HMO) plan that features a primary care physician (PCP) who works with you to coordinate your health care. PCP referrals are not required to receive care from a specialist provider.

COST SHARE PROVISIONS	**In-Network** ***Member pays:***
Office Visit (**OV**) Copayment	$10 per visit
Specialist Visit (**SV**) Copayment	$10 per visit
Hospital (**HSP**) Copayment	No charge
Urgent Care (**UR**) Copayment	$25
Emergency Room (**ER**) Copayment – *waived if admitted*	$50
Outpatient Surgery (**OS**) Copayment	No Charge
Out-of-Pocket Maximum *(Individual/Family)*	$6,850/$13,700
Lifetime Maximum	Unlimited
PREVENTIVE CARE	
Well child care	No Charge
Periodic, routine health examinations	No Charge
Routine OB/GYN visits	No Charge
Mammography	No Charge
Hearing screening	No Charge
MEDICAL CARE	
Office visits *PCP* *Specialist*	 OV Copayment SV Copayment
Outpatient mental health & substance abuse – *prior authorization required after 40 visits*	SV Copayment
OB/GYN care	SV Copayment
Maternity care – *initial visit subject to copayment, no charge thereafter*	SV Copayment
Diagnostic lab and x-ray	No Charge
High-cost outpatient diagnostic	No Charge
Allergy services *Office visits/testing* *Injections—60 visits in 2 years*	 SV Copayment No Copayment
HOSPITAL CARE – *Prior authorization required*	
Semi-private room *(General/Medical/Surgical/Maternity)*	No Copayment
Inpatient mental health & substance abuse	No Copayment
Skilled nursing facility – *up to 90 days per calendar year*	No Copayment
Rehabilitative services – *up to 60 days per person per calendar year*	No Charge
Outpatient surgery – *in a hospital or surgi-center*	No Copayment
EMERGENCY CARE	
Walk-in centers	OV Copayment
Urgent care – *at participating centers only*	UR Copayment
Emergency care – *copayment waived if admitted*	ER Copayment
Ambulance	No Charge

OTHER HEALTH CARE

Outpatient rehabilitative services *Unlimited*	SV Copayment
Durable medical equipment / Prosthetic devices *Unlimited maximum per calendar year – coverage limited to certain items*	20%
Diabetic supplies, drugs and equipment	20%
Infertility services	50%
Home health care (unlimited)	No Charge

PREVENTIVE CARE SCHEDULES

Well Child Care *(including immunizations)*

- 1 exam every year

Adult Exams

- 1 exam every year

Mammography

- 1 baseline screening, ages 35 – 39
- 1 screening per year, ages 40+
- Additional exams when medically necessary

Vision Exams: 1 exam every 2 calendar years

Hearing Exams: 1 exam per calendar year

OB/GYN Exams: 1 exam per calendar year

Notes To Benefit Descriptions

- In situations where the member is responsible for obtaining the necessary prior authorization and fails to do so, benefits may be reduced or denied.
- Inpatient Hospital Per Admission Copay is waived if readmitted within 30 days for same diagnosis
- Skilled Nursing Facility Copay is waived if admitted within 3 days of hospital discharge.
- Home Health Care services are covered when in lieu of hospitalization. Includes infusion (IV) therapy.
- Members must utilize participating Blue Quality Centers for Transplant hospitals to receive benefits for Human Organ & Tissue Transplant services. This network of the finest medical transplant programs in the nation is available to members who are candidates for an organ or bone marrow transplant. A nurse consultant trained in case management is dedicated to managing members who require organ and/or tissue transplants. Covered services are subject to an unlimited lifetime maximum.

Please refer to the *SpecialOffers@Anthem* brochure in your enrollment kit for information on the discounts we offer on health-related products and services.

This does not constitute your health plan or insurance policy. It is only a general description of the plan. The following are examples of services NOT covered by your BlueCare Health Plan. Please refer to your Subscriber Agreement/Certificate of Coverage/Summary Booklet for more details: Cosmetic surgeries and services; custodial care; genetic testing; hearing aids; refractive eye surgery; services and supplies related to, as well as the performance of, sex change operations; surgical and non-surgical services related to TMJ syndrome; travel expenses; vision therapy; services rendered prior to your contract effective date or rendered after your contract termination date; and workers' compensation.

A product of Anthem Blue Cross and Blue Shield serving residents and businesses in the State of Connecticut.

City of Norwich
MANAGED RX, 3 TIER Plan
Benefits at a Glance

$5 COPAYMENT GENERIC DRUGS
$20 COPAYMENT LISTED BRAND-NAME DRUGS
$30 COPAYMENT NON-LISTED BRAND-NAME DRUGS
Unlimited Annual Maximum with Oral Contraceptives

How To Use 3-Tier Managed Rx

3-Tier Managed Rx has three different levels (or "tiers") of copayments, depending on the type of prescription drug you purchase (see the chart below for details). Your copayments will be lower when you use generic or brand-name medications that are on our list of preferred prescription drugs. The medications on this list are selected for their quality, safety and cost-effectiveness. You'll still have coverage brand-name drugs that are not on the list, but your copayment will be higher.

Talk to your provider about using generic drugs or listed brand-name drugs. It's a simple way to save out-of-pocket expenses.

Copayments and Day Supplies

- You will be responsible for **one** copayment when purchasing a **90-day supply** of prescription drugs from a retail pharmacy.
- You'll be responsible for **No** copayment when purchasing a **90-day supply** of maintenance drugs through the voluntary mail-service program.

Generic Drugs Have the Lowest Copayment

		Your copayment:
Tier 1: Generic drugs	The term "generic" refers to a prescription drug that is not protected by a trademark. It is required to meet the same bioequivalency test as the original brand-name drug. Tier 1 copayment applies.	$5
Tier 2: Listed brand-name drugs	The term "listed brand-name" refers to a brand-name prescription drug that is on Anthem Blue Cross and Blue Shield's list of preferred prescription drugs. Tier 2 copayment applies.	$20
Tier 3: Non-listed brand-name drugs	The term "non-listed brand-name" refers to a brand-name prescription drug that is not on Anthem Blue Cross and Blue Shield's list of preferred prescription drugs. Tier 3 copayment applies.	$30
Mail Service	No copayments per 90 day supply	$0
Annual Maximum	Per member per calendar year	Unlimited

Generic Substitution

Prescriptions will be filled with the generic equivalent when there is one available. Exception: If your doctor indicates "Dispense as Written." In this case you will receive the brand-name drug—and you will be responsible for the applicable listed brand or non-listed brand copayment. NOTE: If your doctor does *not* indicate **"Dispense as Written,"** you will be responsible for the applicable listed brand or non-listed brand-name copayment as well as the difference in cost between the generic and listed brand or non-listed brand name drug.

Voluntary Mail-Service Program

Anthem Rx, our voluntary mail-service drug program, can save you time and expense if you regularly take one or more types of maintenance drugs. You can order up to a **90-day supply** of these medications and have them delivered directly to your home.

No **mail-service copayments** will apply when Rx drugs are dispensed for 90 days.

National Pharmacy Network

Members also have access to a network of more than 65,000 retail pharmacies throughout the country. Members may call 1-866-876-0333, or go to www.express-scripts.com, to locate a participating pharmacy when traveling outside the state.

Non-Participating Pharmacies- Applicable to Century Preferred (PPO) plan only

Members who fill prescriptions at a non-participating pharmacy are responsible for payment at the time the prescription is filled. Members must submit claims to Anthem Blue Cross and Blue Shield for reimbursement, and payment will be sent to the member. Members who use non-participating pharmacies will pay 20% of the in-network allowance, plus the difference between Anthem Blue Cross and Blue Shield's payment and the pharmacist's actual charge.

Limits and Exclusions

Benefits are limited to no more than a **90-day supply** for covered drugs purchased at a retail pharmacy, and no more than a **90-day supply** for covered drugs purchased by mail service. All prescriptions are subject to the quantity limitations imposed by state and federal statutes.

Benefits for prescription birth control and Sexual Dysfunction medications are optional for groups such as yours. Check with your benefits administrator to find out whether or not you have such benefits.

This is not a legal contract. It is only a general description of the Managed Rx, 3 Tier version. Please consult the Evidence of Coverage or prescription drug rider for a complete description of benefits and exclusions applicable to your coverage.

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City of Norwich
CENTURY PREFERRED $15/$100/$50/$50

Century Preferred is a preferred provider organization (PPO) plan.

COST SHARE PROVISIONS	**In-Network** *Member pays:*	**Out-of-Network** *Member pays:*
Office Visit (**OV**) Copayment	$15 per visit	Deductible & Coinsurance
Hospital (**HSP**) Copayment	$100	Deductible & Coinsurance
Urgent Care (**UR**) Copayment	$25	Not Covered
Emergency Room (**ER**) Copayment – *waived if admitted*	$50	$50
Outpatient Surgery (**OS**) Copayment	$50	Deductible & Coinsurance
Annual Deductible (*individual/2-member family/3+ member family*)	Not Applicable	$200/$400/$500
Coinsurance		20% after deductible up to
Coinsurance Maximum (*individual/2-member family/3+ member family*)		$800/$1,600/$2,000
Out-of-Pocket Maximum *(individual/2-member family/3+member family)*	$6,850/$13,700/ $13,700	$1,000/$2,000/$2,500
Lifetime Maximum	Unlimited	Unlimited
PREVENTIVE CARE		
Well child care	No Copayment	Deductible & Coinsurance
Periodic, routine health examinations	No Copayment	
Routine eye screenings / One every 2 years	No Copayment	
Routine OB/GYN visits	No Copayment	
Mammography	No Copayment	
Hearing screening / One every 2 years	No Copayment	
MEDICAL CARE		
Office visits	OV Copayment	Deductible & Coinsurance
Outpatient mental health & substance abuse - *prior authorization required*	OV Copayment	
OB/GYN care	OV Copayment	
Maternity care – *initial visit subject to copayment, no charge thereafter*	OV Copayment	
Diagnostic lab and x-ray	No Charge	
High-cost outpatient diagnostic – *MRI, MRA, CAT, CTA, PET, SPECT scans*	No Copayment	
Allergy services *Office visits/testing* *Injections—80 visits In 3 years*	 OV Copayment NO Copayment	
HOSPITAL CARE – *Prior authorization required*		
Semi-private room *(General/Medical/Surgical/Maternity)*	HSP Copayment	Deductible & Coinsurance
Skilled nursing facility – *up to 120 days per calendar year*	HSP Copayment	
Rehabilitative services – *up to 60 days per person per calendar year*	No Charge	
Outpatient surgery – *in a hospital or surgi-center*	OS Copayment	
EMERGENCY CARE		
Walk-in centers	OV Copayment	Deductible & Coinsurance
Urgent care – *at participating centers only*	UR Copayment	Not Covered
Emergency care – *copayment waived if admitted*	ER Copayment	ER Copayment
Ambulance	No Charge	No Charge

OTHER HEALTH CARE	In-Network *Member pays:*	Out-of-Network *Member pays:*
Outpatient rehabilitative services *50 visit maximum for PT, OT, Chiro and ST per year*	No Copayment	Deductible & Coinsurance
Durable medical equipment / Prosthetic devices *Unlimited maximum per calendar year*	No Copayment	
Infertility services *(diagnosis and treatment) No age or cycle restrictions*	Applicable copayment	Deductible & Coinsurance
Home health care – 200/80	No Charge	$50 Deductible & 20 % Coinsurance

PREVENTIVE CARE SCHEDULES

Well Child Care (including immunizations)
- 1 exam every year

Adult Exams
- 1 exam every year

Mammography
- 1 baseline screening, ages 35-39
- 1screening per year, ages 40+
- Additional exams when medically necessary

Vision Exams: 1 exam every 2 calendar years

Hearing Exams: 1 exam every 2 calendar years

OB/GYN Exams: 1 exam per calendar year

Notes To Benefit Descriptions
- In situations where the member is responsible for obtaining the necessary prior authorization and fails to do so, benefits may be reduced or denied.
- Inpatient Hospital Per Admission Copay is waived if readmitted within 30 days for same diagnosis.
- Skilled Nursing Facility Copay is waived if admitted within 3 days of hospital discharge.
- Home Health Care services are covered when in lieu of hospitalization. Includes infusion (IV) therapy.
- Members are responsible for the balance of charges billed by out-of-network providers after payment for covered services has been made by Anthem Blue Cross and Blue Shield according to the Comprehensive Schedule of Professional Services.

Please refer to the *SpecialOffers@Anthem* brochure in your enrollment kit for information on the discounts we offer on health-related products and services.

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City of Norwich
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Talk to your provider about using generic drugs or listed brand-name drugs. It's a simple way to save out-of-pocket expenses.

Copayments and Day Supplies

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Mail Service	No copayments per 90 day supply	$0
Annual Maximum	Per member per calendar year	Unlimited

Generic Substitution

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Members who fill prescriptions at a non-participating pharmacy are responsible for payment at the time the prescription is filled. Members must submit claims to Anthem Blue Cross and Blue Shield for reimbursement, and payment will be sent to the member. Members who use non-participating pharmacies will pay 20% of the in-network allowance, plus the difference between Anthem Blue Cross and Blue Shield's payment and the pharmacist's actual charge.

Limits and Exclusions

Benefits are limited to no more than a **90-day supply** for covered drugs purchased at a retail pharmacy, and no more than a **90-day supply** for covered drugs purchased by mail service. All prescriptions are subject to the quantity limitations imposed by state and federal statutes.

Benefits for prescription birth control and Sexual Dysfunction medications are optional for groups such as yours. Check with your benefits administrator to find out whether or not you have such benefits.

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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.

City of Norwich H S A

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 2016/2017, contributions can be made to your HSA up to the following:

$3,350/$3,450 individual coverage
$6,750/$6,750 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
In Network and Out of Network Providers

$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 Providers:	Out-of-Network Providers:
$ 1,500 individual coverage	$ 3,000 individual coverage
$ 3,000 family 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:
• Future Moms for participation and completion	Up to $200
• Healthy Lifestyles online participation	Up to $150
• ConditionCare participation and completion.	Up to $300

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

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

Healthy Rewards

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

Future Moms: Individualized obstetric support for expectant high-risk and non-high-risk mothers. Members can earn up to a $200 Future Mom's incentive. This includes three milestones: $100 initial enrollment, $50 interim, and $50 postpartum; timing and rules apply.
Healthy Lifestyles Online: Each adult family member can earn up to $150 each year. Members earn a $50 incentive at each 3,000, 5,000 and 10,000 point milestone. Your employees can quickly achieve their first milestone of 3,000 points by completing the Well-Being Assessment and setting up their Well-Being Plan.
Enroll in ConditionCare: (Incentive $100) Disease management for prevalent, high-cost conditions (asthma, diabetes, chronic obstructive pulmonary disease, coronary artery disease and heart failure) . Each family member can get one incentive per year. In the first year and later years, members must stay qualified to enroll and earn incentives. Members who have more than one health problem will enroll in one combined program — not separate ones for each condition.
Graduate from ConditionCare: (Incentive $200) There's no limit to the number of family members that can graduate and earn the incentive. Each family member can earn one credit per year. In the first year and later years, members must stay qualified to enroll, graduate and earn incentives. Members who have more than one health problem will graduate from one combined program — not separate ones for each condition.

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; including preventive vision exams

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; including preventive vision exams.

Screening Tests for 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 limited to 120 days per member per calendar year.
- Home Health care services limited to 200 visits per member per calendar year.
- Inpatient rehabilitative services limited to 100 days per member per calendar year.
- PT/OT/ST and chiropractic services limited to a combined total of 50 visits per member per calendar year.
- Inpatient hospitalizations require authorizations.
- Your Lumenos HSA plan includes an unlimited lifetime maximum for in and out-of-network services.

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

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

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

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.

Anthem BlueCross BlueShield

Using your Anthem Consumer-Driven Health Plan with HSA

Anthem Consumer-Driven Health Plan with HSA: How the HSA-compatible plan works

Your Anthem Consumer-Driven Health Plan with HSA combines a high-deductible health plan with a health savings account (HSA), funded by you with pre- or post-tax contributions. You can use the money in your HSA to pay for medical care and prescriptions that go toward satisfying your annual deductible. Once you've satisfied this deductible, your traditional health coverage — similar to a PPO or HMO — kicks in. You'll pay the appropriate coinsurance for covered services, up to your plan's annual out-of-pocket maximum. If you've met your annual out-of-pocket maximum, the plan will pay 100% of the cost of your covered services, up to the allowed amount.

All of this makes your Anthem Consumer-Driven Health Plan with HSA different from a conventional plan. But, getting access to care and filling a prescription is easier than you may think. Here's what to expect.

Show your ID card

After you've enrolled, you'll receive your Anthem ID card. Just present this ID card when you visit your provider and point out the Anthem Blue Cross and Blue Shield logo.

Schedule a preventive care appointment

If you're receiving covered preventive care services, don't forget to tell your doctor that your plan covers up to 100% of the service — as long as you receive care from a network provider. (See your Plan Summary for details.)

Visit any licensed doctor or hospital

With the Anthem Consumer-Driven Health Plan with HSA, you can visit any licensed doctor, hospital or medical provider you want. However, the method of payment and the cost of the service may vary, depending on whether the doctor is in Anthem's network or not.

Network providers:

If your provider participates in Anthem's network, the office staff will usually take care of most of the work. Typically, you won't pay at the time you receive service. Instead, the office staff will photocopy your ID card and file the claim for you. It is important to allow them to file the claim on your behalf before you pay so you benefit from the network discounts.

- After your claim is processed, Anthem will send you and your provider a Claim Recap which shows the total cost of the service, the "allowable charge" (the provider's contracted rate) and the amount you are responsible for paying.
- Your provider will send you a bill for any charges you are responsible to pay.
- If you have enough funds in your HSA, you can use your HSA debit card or check to pay the bill. If you do not have adequate funds in your HSA or you choose not to use your HSA, you will need to pay out of your own pocket.
- The amount you pay on covered services will go toward your deductible and out-of-pocket maximum.

Out-of-network providers:

If you see a provider who isn't in the network, you may have to pay for your service at the time of your appointment. Keep in mind: You may be responsible for the total cost of service when using an out-of-network provider. If you have money available in your account, you can use your HSA debit card or check to pay for the service or you may pay out of pocket. Your provider may file the claim for you. Or, you may have to file the claim yourself to help ensure your covered expenses are applied to your plan's annual deductible and out-of-pocket maximum. You can get a claim form at anthem.com.

DID YOU KNOW?

If you pay out of pocket for a service, you can reimburse yourself from your HSA. Once you have funds available in your HSA, simply write yourself a check for the amount of the out-of-pocket expense. Just be sure to keep your receipt for tax purposes.

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How the HSA-compatible plan works for prescriptions

Getting a prescription is easy with the Anthem Consumer-Driven Health Plan with HSA — especially when you consider that you have access to a large network of participating pharmacies to choose from. Here's what you'll do.

Visit your local pharmacy

Your Anthem ID card is also your prescription card. Simply present your ID card when you visit your pharmacy to help ensure you receive the right discount for your prescription. Remember, you'll get better discounts when you use a network pharmacy.

The way you pay for your prescription depends on the following:

- If you have funds in your HSA to cover the cost of your prescription, you can use your HSA debit card or check to pay for the prescription at the pharmacy. The full discounted cost of the prescription will automatically be deducted from your account and will apply toward your annual deductible. Medical and prescription deductibles are not separate!
- If you don't want to tap into your HSA, you can pay directly from your wallet. The cost of the prescription will still be applied toward your annual deductible.
- Once you have met your deductible and your traditional health coverage has kicked in, you'll pay only the appropriate coinsurance or copayment at the pharmacy, up to your plan's annual out-of-pocket maximum. If you have met your annual out-of-pocket maximum, the plan will pay 100% of the cost of your covered medications, up to the allowed amount. (See your Plan Summary for details.)

Use our mail order pharmacy and save

You can also order your prescriptions through our mail order pharmacy. This is easy and convenient because it saves you a trip to a retail pharmacy. Plus, you'll pay the amount the mail order pharmacy charges for the drug, which may be less than what you'd pay at a retail pharmacy. The way you pay works the same. You'll just provide a credit card number when you submit the mail service form. Your card will only be charged if you don't have sufficient funds in your HRA account.

Stretch your health care dollars with generics

Want to save money, so you can get even more from your HRA funds? Many times, you'll have the choice between a name brand drug and its generic equivalent. Generics are just as safe and effective as brand-name drugs, but they cost about 41% less![1] The next time the provider prescribes a medication, ask about generic alternatives and if they could work for you.

1 Trends in Brand Name and Generic Prescribed Medication Utilization and Expenditures, 1999 and 2003; AHRQ Statistical Brief #144. October 2006.

Find the answers here

Frequently asked questions (FAQs) about your CDHP with HSA

Table of contents

Health savings account (HSA)

Q. What is a health savings account (HSA)?

A. An HSA is a special tax-sheltered savings account used with medical plans called consumer-driven health plans (CDHPs). By law, to open or contribute to an HSA, the medical plan must be a qualified "high-deductible health plan." This means the deductible is higher than a traditional medical plan's deductible. You can use the money in your HSA to help pay your deductible, your coinsurance and other qualified in-network or out-of-network expenses. You can also save money in your health savings account for future health care costs. The account grows with interest. And you have investment options after your account reaches a minimum balance of $1,000. The HSA belongs to you and the money in the account is yours to keep, even if you leave your employer.

Q. How is my HSA funded?

A. Your HSA is funded by your own pre-tax contributions, up to a certain annual limit. You may also contribute money to your HSA after taxes are taken out. Others (including your employer) may contribute to your account as well. You also can earn more dollars for your HSA by taking certain steps to improve your health. The total of all contributions cannot be more than the maximums defined by the U.S. Treasury and the Internal Revenue Service (IRS). (See the question below: How much can I contribute to my HSA? for details.)

Q. Who can open an HSA?

A. To be eligible, you must meet the following criteria:

- You must be covered by an HSA-compatible health plan, such as the CDHP with HSA plan, and you cannot be covered by any other medical plan that is not an HSA-compatible health plan. This would include being enrolled in your spouse's plan as secondary coverage. Federal law requires minimum deductible levels for individual and family coverage for HSA-compatible health plans.

Anthem BlueCross BlueShield

- You must be enrolled in the plan on the first day of the month; otherwise, your eligibility to make contributions to your HSA begins the first day of the following month. You may make the maximum annual HSA contribution for the year regardless of the month you become eligible. You must remain enrolled in the HSA-compatible health plan for 12 months of the following tax year.
- You must not be enrolled in Medicare.
- If you are a veteran, you may not have received veterans' benefits within the last three months.
- You must not be on active military status.
- You must not be eligible to be claimed as a dependent on another person's tax return.

The IRS has specific rules on who can open an HSA. See those rules in **IRS Publication 969**.[1]

Q. Can I enroll in the CDHP with HSA if my spouse is on Medicare?

A. Yes, as long as you are not enrolled in Medicare and you meet the IRS eligibility requirements for an HSA, you can enroll in the CDHP with HSA. You can contribute to an HSA and you may choose to cover your spouse on your plan and use the funds in your HSA to pay for qualified medical expenses for you and your spouse on Medicare.

Q. My spouse is enrolled in Medicare. Can he or she also be enrolled as a dependent on the CDHP with HSA?

A. Yes, but your spouse cannot open an HSA account in his or her own name because he or she is on Medicare. You may use the funds in your HSA to pay for qualified medical expenses for you and your spouse on Medicare.

Q. If my spouse is on Medicare and I am not on Medicare, how much can I contribute to an HSA?

A. If you are enrolled in family coverage (two or more people), the IRS will only allow you to set up an HSA. You may contribute up to $6,750 in 2016. You can use the HSA funds to pay for your spouse's out-of-pocket expenses, even if he or she is on Medicare.

Q. I am enrolled in Medicare Part A as I continue to work. Can I enroll in the CDHP with HSA?

A. Yes, you can enroll in the CDHP with HSA if you have Medicare Part A. However, you will not be eligible to make contributions to the HSA.

Q. Who can use the money in an HSA?

A. The money can be used for qualified health care costs for you, your spouse or any IRS-qualified dependent who you claim on your income taxes, whether or not he or she is covered on your health care plan. Talk with a tax advisor to find out if these rules apply to your tax situation. You can also go to **irs.gov** to find out who qualifies as a dependent.

You may not use the HSA funds for health care costs for a domestic partner or child who does not qualify as your tax dependent. If your domestic partner is covered by your CDHP with HSA plan, he or she can set up his or her own HSA at a financial company that manages HSA plans.

Payments for a dependent who doesn't meet the definition of "tax dependent" may be considered nonqualified costs. This means you may have to pay taxes and penalties for these payments. For more details about eligible expenses and dependents for HSAs, see **IRS Publication 969**.[1] Keep in mind that this document changes regularly and you should check with your tax adviser if you have questions.

Q. I am enrolled in the CDHP with HSA. Can I continue to contribute to my spouse's HSA and use his or her bank?

A. You and your spouse can continue to make contributions to his or her HSA, but you cannot contribute more than the IRS family contribution maximum between both HSA accounts. For 2016, the family contribution maximum is $6,750.

Q. My child is under 26 but I no longer claim him or her on my taxes. Can I cover him or her on the CDHP with HSA?

A. The IRS has specific rules about covering a child. See **IRS Publication 969**.[1] You can cover dependents under age 26 in the CDHP with HSA, but you can't use your HSA account for their expenses unless they meet the following requirements:

- Account holder must be able to claim the child on his or her tax return.
- Your child is under age 19 or under age 24 if a full-time student, or totally and permanently disabled.

Dependents who do not qualify to receive funds from your HSA may qualify to open their own HSA and could be permitted to contribute up to the family maximum (for 2016, this is $6,750). They can contact a financial institution to discuss how to set up a separate HSA.

Q. My child is under age 26 and married. Can I cover him or her on my medical plan?

A. Yes, eligible dependents can be covered to the age of 26. Under health care reform, this applies to all dependent children up to age 26, regardless of student, employment, residential or marital status.

- The health care reform law expanded the definition of eligible dependents to age 26 for medical plan coverage, FSAs and health reimbursement accounts (HRAs).
- The law did not expand the definition of eligible dependent to age 26 for HSA expenses. Therefore, employees can use HSA funds tax-free only for eligible expenses of family members who meet the definition of a "tax dependent" in the Internal Revenue Code. Please refer to the previous Q&A.
- Disbursements for children who don't meet this stricter definition may be considered nonqualified expenses, which are subject to tax and penalties. That means you'll pay a penalty plus taxes if you use the pretax dollars from your HSA to pay health expenses for your older covered dependent if he or she does not meet the IRS definition of a tax dependent.
- Please refer to the **IRS Publication 969**[1] for more information or speak with your tax adviser.

Q. I do not have custody of my two children. I do not claim them on my tax return. Can I use funds in my HSA to pay for their qualified health care costs?

A. For purposes of medical and dental expense deductions, a child of divorced or separated parents can be treated as a dependent of both parents. Each parent can include the health care costs he or she pays for the child, even if the other parent claims the child's dependency exemption, if:

- The child is in the custody of one or both parents for more than half the year.
- The child receives more than half of his or her support during the year from his or her parents.
- The child's parents:
  - —Are legally divorced or separated.
  - —Are separated under a written agreement.
  - —Lived apart at all times during the last six months of the year.

This does not apply if the child's exemption is being claimed under a multiple support agreement.

To find out more about covering children and children of divorced or separated parents, please see **IRS Publication 969**[1] and talk with a tax adviser.

Q. If I am covering a child who is age 23 and I cannot claim him or her as a tax dependent, what is my maximum contribution to an HSA on a pretax basis?

A. If the child cannot be claimed as a tax dependent, the child is eligible to establish his or her own HSA and can contribute up to the family maximum ($6,750 for 2016). The employee also can contribute up to the family maximum in his or her HSA in this example.

Q. I have an HSA with another bank. Can I keep it? Do I have to open an account with your partner bank?

A. You can keep the HSA account you have. But, all contributions from your paycheck will only go to your employer-sponsored HSA. Also, you will have to pay any bank charges for your other HSA.

Q. What is the difference between an HSA and a health care flexible spending account (FSA)?

A. Both HSAs and FSAs can be funded with pre-tax dollars and be used to pay for medical expenses. However, HSA balances can roll over from year to year, while FSA money is forfeited if it is not spent during a 12-month period. And, if you leave your employer, your HSA dollars are yours to keep. FSA dollars are forfeited.

Q. Can I have an HSA and an FSA?

A. Yes, you are eligible to have both an HSA and an FSA only if the FSA has been defined as either a:

- **Limited/Special Purpose FSA**, which may be limited to dental or vision services.
- **Limited Purpose High-Deductible FSA**, which also allows for dental or vision services, as well as paying for coinsurance under the traditional health component of the plan, after meeting the deductible.

Making contributions to your HSA

Q. How do I make contributions to my HSA?

A. If your employer allows it, the easiest way is through pretax payroll deductions. However, you may also contribute directly to your HSA after taxes. To make after-tax contributions, call your HSA financial company or go online to the financial company's member website and set up an electronic fund transfer from your personal bank account.

Q. How much can I contribute to my HSA?

A. The annual contribution maximum in 2016 is $3,350 for individual coverage and $6,750 for family coverage. The maximums are set by the U.S. Treasury and the IRS. Those maximums may go up every year for inflation. Check **irs.gov** for the most current maximum amounts.

Q. Can I ever contribute more than the annual limit?

A. Yes, people aged 55 and older who are not enrolled in Medicare can contribute an extra $1,000 above the regular limits. This is called a "catch-up contribution." These individuals can make catch-up contributions each year until they enroll in Medicare.

Only the account holder can make catch-up contributions. The contribution amounts allowed are subject to proration if you are enrolled in the plan less than 12 months or under other circumstances. Catch-up contributions can be made in the same way your regular contributions are made.

Q: If I am 55 and older and my spouse is too, can we both make catch-up contributions?

A. If only one spouse has an HSA in his or her name, only that spouse can make a catch-up contribution. If both of you want to make catch-up contributions when you are age 55 or older, you must establish separate HSA accounts. Please note the contribution combined cannot be more than the IRS family contribution maximum.

Q. What if I contribute too much to my account during a year and go over the annual maximum allowed?

A. If you contribute too much to your account, IRS rules require that you pay regular income tax, plus a tax penalty on the amount you went over. If you realize you've contributed too much before you file your taxes, you may choose to submit a form showing these contributions to the HSA financial company to remove those excess funds. Different rules apply if you contributed too much because you left the plan during the year. See the question *What if I end my coverage before the end of the year?* to find out more.

Q. What if I end my coverage before the end of the year?

A. You take that money with you wherever you go. The HSA is in your name and it's your account. If you're on Medicare or go to another employer who doesn't have a qualified high-deductible health plan, you can still use your HSA money to pay for copays and qualified medical expenses. However, you won't be able to continue to make contributions to your HSA unless you continue to participate in an HSA-compatible plan.

If you leave during the year and do not enroll in another HSA-compatible plan, the annual contribution maximum is prorated. This is based on the number of months that you were enrolled in an HSA-compatible plan. If you fund your account for the entire year, then leave the plan and do not join another HSA-compatible health plan, you will need to withdraw the excess funds before the end of the tax year. You'll have to treat these funds as taxable income if you have over-funded the account. If you don't, you may have to pay tax penalties.

For example, let's say Mary was enrolled in the CDHP with HSA and changes jobs on July 1, 2016, and is no longer eligible to contribute to her HSA. She would figure out her health savings maximum contribution amount for that year this way:

$3,350 x 6 months / 12 months = $1,675

You can contact your HSA financial company if you have questions about your account.

Q. What if my spouse has an HSA, too?

A. The chart below explains different situations:

If your spouse:	And you have:	Then, the IRS:
Has PPO (preferred provider organization) self + children coverage.	HDHP (high-deductible health plan) self-only coverage.	Treats you as having single coverage and only you may set up an HSA (health savings account). You may contribute up to $3,350.
Has HDHP self-only coverage with a $1,500 deductible.	HDHP self + child coverage with a $3,000 deductible.	Treats you both as having family coverage, and combined you may contribute up to $6,750 to an HSA.
Has HDHP self + family coverage with a $3,000 deductible.	HDHP self + spouse coverage with a $3,000 deductible.	Treats you both as having family coverage, and combined you may contribute up to $6,750 to an HSA.
Is enrolled in Medicare.	HDHP self + family coverage only.	Will only allow you to set up an HSA. You may contribute up to $6,750.

Q. Does tax filing status (joint vs. separate with my spouse) affect my HSA contribution?

A. Tax filing status does not affect your contribution. The IRS requirements simply refer to eligible expenses for the "spouse" — they do not include requirements for filing jointly or separately. However, the IRS indicates that children must be tax dependents. **IRS Publication 969**[1] has more details. See the question *I do not have custody of my two children* to learn more.

Q. Can I use the HSA account for eligible expenses for my spouse even if we file our taxes separately?

A. Yes, the IRS requirements simply refer to eligible expenses for the "spouse" — they do not include requirements for filing jointly or separately. However, the IRS indicates that children must be tax dependents. IRS Publication 9691 has more details.

Q. I am going to enroll in the CDHP with HSA. What happens if my spouse chooses coverage under a health care FSA?

A. Usually, a health care FSA covers the expenses of the participant and the participant's spouse and dependents. If your spouse has a health care FSA, most likely your health care costs are covered under your spouse's FSA. If so, then you won't be able to make contributions to your HSA.

There are exceptions to this rule. For example, if your spouse's FSA is a limited-purpose FSA that only covers dental and vision costs.

Q. Can I use my HSA to pay for medical expenses before I set up my account?

A. No. You cannot be reimbursed for qualified medical expenses before the date your HSA account is established.

Q. What happens if I have a medical expense early in the year and there isn't enough money in my HSA to cover my out-of-pocket costs?

A. The HSA works like a bank account. You can only spend what is in the account. However, you can start the reimbursement process for any services incurred after you enrolled in the HSA when you have more funds in your account.

Q. What counts toward my out-of-pocket maximum?

A. The out-of-pocket maximum adds together your deductible and the percentage you shared in the cost for covered expenses (your coinsurance or portion of the cost). Once you reach the maximum out-of-pocket, the plan pays covered expenses at 100% for the rest of the year.

It's very important to understand that if the provider's charge is more than our maximum allowed amount for out-of-network services, you will be responsible for paying the difference. Out-of-network providers can bill you for balances above the amount your plan pays, even if you've paid your out-of-pocket maximum.

Q. Are deductibles included in the out-of-pocket maximum for the CDHP with HSA?

A. Yes, deductibles and coinsurance for your medical and pharmacy costs are included in the out-of-pocket maximum. This includes your prescription drug costs.

Q. Once I reach my out-of-pocket maximum, do I still have to pay for office visits and prescriptions?

A. No. Once you meet your out-of-pocket maximum, the plan pays 100% for covered expenses. If you use out-of-network providers they can bill you for the amount above what we allow and this will be your responsibility to pay.

Q. Are dental and vision care considered qualified medical expenses for purposes of a health savings account?

A. Yes, many dental, orthodontia and eye care expenses are considered qualified medical expenses. However, cosmetic procedures, like cosmetic dentistry, would not be considered a qualified medical expense. For a detailed list, please see **IRS Publication 502**.[2]

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 and save year after year. Your HSA can help you pay for future health care costs.

Q. How can I find out more about HSA regulations?

A. Go to the U.S. Treasury website at **treasury.gov** and type HSA in the search box. You may also read **IRS Publication 969**.[1]

Services covered by your medical plan

Q. What is traditional health coverage?

A. Once you meet your deductible in a CDHP with HSA plan, the plan works like a preferred provider organization (PPO) plan. You pay coinsurance (a percentage of what the provider can charge) when you go to a network provider. You'll pay more if you go to a provider who is not in the network. Check your plan summary to find out more about coinsurance.

Q. What services does the CDHP with HSA plan cover?

A. It covers services that are usually covered by a typical health plan. That includes things like office visits, prescription drugs and major surgeries. Check your plan summary to see some of the services covered by your plan.

You can use your HSA to pay for qualified health care costs not covered by your plan. For a list of qualified medical expenses, see **IRS Publication 502**.[2]

Q. What about preventive care services like mammograms and checkups?

A. The medical plans cover preventive care services like checkups, vaccines and mammograms at 100% when you use a provider in the network. You won't have to pay anything out of your own pocket when you get care from a network provider. You may choose to use your HSA funds to cover these costs.

Q. How do I know what is considered preventive care?

A. Our medical plans cover preventive care services like checkups, vaccines and mammograms at 100% when you see a network provider. Your Summary Benefit Description shows which services are covered by your plan. In addition, this brochure gives you a general understanding of what is covered under preventive services.

Managing the money in your HSA

Q. Who holds the money in my HSA?

A. A qualified financial institution holds it and handles those records. If your employer selects an Anthem partner bank, we will handle all of the enrollment administration for you.

Q. How do I find out my HSA balance?

A. It's easy. First register at anthem.com after you get your medical ID card. Then, log in and go to the bank website. There, you can see your account balance, transactions and manage your personal information online.

Q. Will I have to register to use the site the first time I log in to the bank website through anthem.com?

A. Yes, the first time you go to the HSA bank website from anthem.com, you will need to set up a username and password. After you do that, you will be able to use the banking site member website through anthem.com. Also, you will be able to use the bank website username and password to access your information directly through their website and through their mobile application.

Q. How do I access the money in my HSA?

A. You will receive a debit card to use to pay for eligible expenses when funds are available. You also can make payments online at the HSA bank website. You can pay the provider directly or get reimbursed for an eligible cost online.

Q. Will my HSA earn interest?

A. Yes. The HSA is an interest-bearing account.

Q. Can I invest my HSA?

A. Yes. You'll need to have at least $1,000 in your HSA before you can invest it. You can invest in certain mutual funds after you reach the $1,000 minimum balance in your account.

Q. Are the interest and investment earnings in my HSA tax-free?

A. Yes, when the funds are distributed and used for qualified health care costs. Interest and investment earnings grow tax-deferred in the account. That means you'll only be taxed if funds are withdrawn for non-health care costs.

Q. Are any administrative fees charged to my HSA?

A. Yes, you'll have to pay banking fees, such as overdraft charges or charges for debit cards to replace lost ones. When you enroll in the program, you will get information about the account.

Q. Is there a time restriction on when I may use the funds in the account?

A. No. Once funds are put into the HSA, they may be used at any time in the future for qualified health care costs.

Q. If I leave the medical plan, what happens to my HSA?

A. You own the HSA; the money is yours to keep. You may choose to keep the funds in your account or roll the funds into a different account. If you leave the funds in your account, you will have to pay fees to keep it. If you retire and are insured by Medicare, change to a health plan that is not an HSA-compatible plan or go to another employer that doesn't offer an HSA-compatible plan, you can still use your HSA to pay for out-of-pocket qualified health care costs. But you won't be able to continue to make contributions to your HSA.

Q. Can I roll over funds from my HSA to another HSA if I leave the program?

A. Yes. Contact your new HSA administrator for help with the rollover process.

Q. What if I use HSA funds to pay for nonqualified health care costs?

A. If you realize you've used HSA funds for nonqualified health care costs before you file your taxes, you can fill out a form showing these contributions, along with a check to put the funds back in your HSA. If you've filed your taxes and did not return the funds, the amount you spent on the nonqualified expense will be considered part of your taxable income. You will also owe a 20% penalty on that amount if you are under age 65.

Q. Do I have to use funds from my HSA to pay for health care costs?

A. No. You may pay out of pocket with after-tax dollars and let your HSA balance grow tax-free.

Tax benefits

Q. What are the tax benefits of an HSA?

A. There are several benefits:

- Contributions to the account are (federal) tax-deferred or tax-advantaged.
- Any investment and interest earned in your account are (federal) tax-deferred.
- Withdrawals from the account for qualified health care costs are (federal) tax-free.
- Depending on the state where you live, you may save on your state tax as well.

Choosing health care providers

Q. What is the difference between in-network and out-of-network providers?

A. Network providers are doctors, hospitals, facilities and other health care providers who are part of the network. That means they have a contract with us and will accept the amount we allow as payment in full for certain covered services. This large network includes many providers and specialists so you find the care you need.

You can even find network care when you travel across the country with the BlueCard® PPO program, which is included with your plan. Just call **1-800-810-BLUE** if you need care away from home.

Out-of-network providers do not have a contract with us and have not agreed to accept the amount we allow as payment in full for specific covered services. This means out-of-network providers may charge more for services than what the network providers agree to accept. If you see an out-of-network provider, you'll pay a higher coinsurance, plus any provider charges above what we allow.

Q. How do I know if my doctor is in the network?

A. You can search the provider network by going to anthem.com and selecting **Find a Doctor**. Follow the steps and select your plan. If you need more help, call the Member Services number on the back of your ID card.

Q. If my doctor isn't in the network, can I still use his or her services?A.You can go to any doctor you choose. And you don't need a referral to see a specialist. However, you'll save money when you go to a network doctor. Also, if you see an out-of-network doctor, you may have to file a claim yourself. You can download a claim form at anthem.com.

Q. Can I go to any doctor or hospital when I travel away from home?

A. Yes. Many providers throughout the country are part of the BlueCard PPO® program. To find a network doctor or hospital when you travel, call **1-800-810-BLUE**. However, if you see an out-of-network provider, you may end up paying more out of pocket.

Q. If I need to file a claim, how do I get reimbursed?

A. In most cases, you won't need to file a claim if you go to a network provider. If you go to an out-of-network provider, you might have to file the claim. If so, send your claim to us for reimbursement. You can download a claim form at anthem.com.

Prescription drug coverage

Q. Does the HSA plan cover prescription drugs?

A. Yes. Show your ID card when you go to your pharmacy. If you have funds in your HSA, you can choose to use your HSA debit card for your share of the cost at the pharmacy. You also can use your HSA debit card for your cost when you use the home delivery pharmacy service if you have funds available.

If you have used all of the funds in your HSA — or choose not to use these funds and save them for future use — you will have to pay out of pocket until you meet your annual deductible before the traditional health coverage part of the plan begins. Then, you will pay any coinsurance for your prescription drugs. Check your plan summary to find out more about your prescription drug benefits.

Q. Is there a preferred drug list for the HSA plan?

A. No, you don't have to use medications from a preferred drug list.

Q. Do I need to get preauthorization for any drugs?

A. Some medications are not covered unless you first get approval through a coverage review process. To save you time and help avoid any confusion, check to see if your medication requires coverage review (prior authorization) by calling Member Services at the number on your medical plan ID card.

Some medications may be covered, but they may have limits (like only for a certain amount or for certain uses and lengths of time) unless you get approval through a coverage review. Before the medication may be covered under your plan, we will ask your doctor for more information to make a decision.

Q. Do my prescription costs apply to my out-of-pocket maximum or my medical deductible?

A. Yes, prescription drug costs apply to your annual deductible and the medical annual out-of-pocket maximum. Once you meet your deductible, you begin to pay the copay or coinsurance.

Q. How do I submit prescriptions to the home delivery pharmacy?

A. Home delivery pharmacy is an easy and cost-effective way for you to get a medication for an ongoing condition. We encourage you to use the member website to download the most up-to-date home delivery order form, which will help speed up the processing of the home delivery prescription order. You can access and download the Express Scripts prescription order form by logging in to the anthem.com member website and selecting Pharmacy, which will take you to the Express Scripts website. Prescription order forms for home delivery are available to download from the site. You also will get a printed order form with each order that's filled by the Express Scripts pharmacy.

Q. Do I need to use a particular pharmacy for specialty drugs?

A. Please contact Member Services to find out more about specialty drug coverage.

Q. How do I get the most out of my pharmacy benefits?

A. There are a few key steps to take to get the most out of your pharmacy benefits:

- Show your ID card when you drop off your prescriptions.
- Have your prescriptions filled at a participating pharmacy.
- Ask for generic drugs to lower your out-of-pocket cost.
- When possible, use the home delivery pharmacy for your prescriptions.

Health and wellness programs

Q. What are health and wellness programs?

A. Our health and wellness programs provide you with resources, tools, guidance and support to help you manage your health and make more informed health care decisions. Just a few of the tools and health coaching programs are described below. Register and log in at anthem.com for more details.

Q. What health and wellness programs are available?

A. The health and wellness programs listed below are available to you at no extra cost to you.

- **ConditionCare** — Helps members manage chronic conditions such as asthma, diabetes, heart failure, coronary artery disease (CAD) and chronic obstructive pulmonary disease (COPD).
- **Future Moms** — Helps mothers-to-be make informed decisions for a healthy pregnancy and delivery.

Q. What is the Healthy Lifestyles Online program?

A. An online program focusing on physical, social and emotional behaviors impacting your total well-being. With this program, you take charge of your total wellness through a personalized well-being plan and custom trackers that help you manage your physical and mental health. Plus you can earn rewards for taking part in some of Anthem's health programs.

Q. How does Healthy Lifestyles Online help me earn incentives?

A. Each adult family member can earn up to $150 each year. Members earn a $50 incentive at each 3,000, 5,000 and 10,000 point milestone. You can quickly achieve their first milestone of 3,000 points by completing the Well-Being Assessment and setting up their Well-Being Plan.

What if I have questions?

Q. How does the money I contribute to my HSA help me save on taxes?

A. Any money you contribute to your HSA is considered (federal) tax-deductible. That means it's not counted as taxable income for the year. So, if you put $1,000 into your HSA, your adjusted gross income for the year is lowered by $1,000, which could save what you owe for taxes, depending on your tax status.

Q. What should I do with the receipts for services I had?

A. You should keep them. Since you own the HSA, you are responsible for giving documentation to the IRS, if you ever need to, for the expenses charged to your HSA. You can upload your receipts to the bank's member website and save them to your HSA member website. You can do this online or through your mobile phone.

Q. Are there any special instructions for filing my taxes?

A. Yes. You will have to complete a *Form 8889* to report your HSA contributions and distributions when you file your taxes. Information from *Form 1099-SA* mailed to you by financial institution by early February shows annual distributions. You can find Form 8889 and instructions at **irs.gov**.

You'll receive *Form 5498-SA* from the HSA bank each May. It's for your information only. You don't need to file it with your tax return. And you'll need to keep track of your receipts for anything you pay for from your account in case you need to give documentation to the IRS to show you used any HSA funds on qualified health care costs. Please talk with a tax adviser to make sure you file your taxes correctly.

Q. Who do I contact if I have questions about my plan?

A. Please contact us with any questions you have about your plan. You can reach Member Services by calling the number on the back of your ID card or visiting anthem.com. You and your family members should receive your ID cards by your effective date of coverage. If you don't receive them, or if you misplace one, please contact us.

Your privacy

Q. Is your website secure?

A. Yes. Our customer-only website is secure and password-protected. Your personal information is kept safe using the highest encryption level available.

Q. What is your privacy policy?

A. You can read the Privacy Policy anytime at anthem.com.

The information included does not constitute legal, tax, or benefit plan design advice. We strongly encourage you to consult with a tax adviser before establishing a health savings account. Any health savings account will be established between the individual account holder and the HSA custodian or trustee. Anthem is responsible for the administration of the health plan, and the custodian is responsible for the administration of the HSA.

1 http://www.irs.gov/pub/irs-pdf/p969.pdf

2 http://www.irs.gov/pub/irs-pdf/p502.pdf

CO-PAY DENTAL with Riders A,B & C

The Co-Pay Dental plan covers diagnostic, preventive and restorative procedures necessary for adequate dental health.

COVERED SERVICES INCLUDE:

- ✓ Oral Examinations
- ✓ Periapical and bitewing x-rays
- ✓ Topical fluoride applications for members under age 19
- ✓ Prophylaxis, including cleaning, scaling and polishing
- ✓ Relining of dentures
- ✓ Repairs of broken removable dentures
- ✓ Palliative emergency treatment
- ✓ Routine fillings consisting of silver amalgam and tooth color materials; including stainless steel crowns (primary teeth)*
- ✓ Simple extractions**
- ✓ Endodontics-including pulpotomy, direct pulp capping and root canal therapy (excluding restoration)

*Payment for an inlay, onlay or crown will equal the amount payable for a three-surface amalgam filling when the member is not covered by Dental Amendatory Rider A.

**Payment for a surgical extraction or a hemisection with root removal will equal the amount payable for a simple extraction when the member is not covered by the Dental Amendatory Rider A.

ACCESSING BENEFITS:

Participating Dentists Benefits
When a member receives care from one of over 1,800 Participating Dentists, he or she simply presents his or her identification card showing dental coverage. The dentist bills us directly for all covered services. For dental care provided by a Participating Dentist, we will pay the lesser of eighty percent of the dentist's usual charge or eighty percent of the Usual, Customary and Reasonable charge as determined by us. The dentist accepts the allowance upon which the payment is based as payment in full and will make no additional charge to the member except for the remaining coinsurance balance.

Non-Participating Dentists Benefits
For covered dental services provided by a Non-Participating Dentist, in or out of Connecticut, we pay the lesser of eighty percent of the dentist's charge or the applicable allowance for the procedure, as determined by us. The member is responsible for any difference between the amount paid by us and the fee charged by the dentist.

This does not constitute your health plan or insurance policy. It is only a general description for the purposes of this Request for Proposal, of the Anthem Blue Cross and Blue Shield of Connecticut Co-Pay Dental Plan. Refer to your Master Group Policy or Description of Benefits, on file with your employer, for a complete listing of benefits, maximums, exclusions and limitations.

Dental Amendatory Rider A
Additional Basic Benefits

In addition to the services provided under your dental program, the following additional basic benefits are provided:

- Inlays (not part of bridge)
- Onlays (not part of bridge)
- Crown (not part of bridge)
- Space Maintainers
- Oral surgery consisting of fracture and dislocation treatment, diagnosis and treatment of cyst and abscess, surgical extractions and impaction
- Apicoectomy

The dental services listed above are subject to the following qualifications:

We will pay for individual crowns, inlays and onlays only when amalgam or synthetic fillings would not be satisfactory for the retention of the tooth, as determined by us.

We will not pay for a replacement provided less than five (5) years following a placement or replacement which was covered under this Rider. We will not pay for individual crowns, inlays or onlays placed to alter vertical dimension, for the purpose of precision attachment of dentures, or when they are splinted together for any reason.

ACCESSING BENEFITS:

Participating Dentists Benefits

Anthem Blue Cross and Blue Shield will pay the lesser of 50% of the dentist's usual charge or 50% percent of the Usual, Customary and Reasonable Charge, as determined by us, for the dental services described in this Rider. Dentists who participate in our dental programs agree to accept our allowance as full payment and may not bill the member for any additional charges except for the remaining coinsurance balance.

Non-Participating Dentists Benefits

In the event these services are rendered by a non-participating dentist, we will pay to the member the lesser of 50% of the dentist's charge or 50% of the applicable allowance for the procedure as determined by us. The member is responsible for any difference between the amount paid by us and the fee charged by the dentist.

This does not constitute your health plan or insurance policy. It is only a general description for the purposes of this Request for Proposal, of the Anthem Blue Cross and Blue Shield Dental Amendatory Rider A. Refer to your Master Group Policy or Description of Benefits, on file with your employer, for a complete listing of benefits, maximums, exclusions and limitations.

Dental Amendatory Rider B
Prosthodontics

The following prosthetic services are provided under Dental Amendatory Rider B:

- Dentures, full and partial
- Bridges, fixed and removable
- Addition of teeth to partial dentures to replace extracted teeth

The dental services listed above are subject to the following qualifications:

Anthem Blue Cross and Blue Shield will pay for standard procedures for prosthetic services as determined by us. For fixed bridges, we will pay for the replacement of missing teeth and for one tooth on either side or two teeth on one side of the replacement. We will not pay for a denture or bridge replacement which is provided less than five years following a placement or replacement which was covered under the contract. We also will not pay for crowns splinted together for any reason.

ACCESSING BENEFITS:

Participating Dentists Benefits

Anthem Blue Cross and Blue Shield will pay the lesser of 50% of the dentist's usual charge or 50% of the Usual, Customary and Reasonable Charge, as determined by us, for the dental services described in this Rider. Dentists who participate in our dental programs agree to accept our allowance as full payment and may not bill the member for any additional charges except for the remaining coinsurance balance.

Non-Participating Dentists Benefits

In the event these services are rendered by a non-participating dentist, we will pay to the member the lesser of 50% of the dentist's charge or 50% of the applicable allowance for the procedure as determined by us. The member is responsible for any difference between the amount paid by us and the fee charged by the dentist.

This does not constitute your health plan or insurance policy. It is only a general description for the purposes of this Request for Proposal, of the Anthem Blue Cross and Blue Shield Dental Amendatory Rider B. Refer to your Master Group Policy or Description of Benefits, on file with your employer, for a complete listing of benefits, maximums, exclusions and limitations.

Dental Amendatory Rider C
Periodontics

Periodontal services consisting of:

- Gingival curettage
- Gingivectomy and gingivoplasty
- Osseous surgery, including flap entry and closure
- Mucogingivoplastic surgery
- Management of acute infection and oral lesions

The maximum benefit we will provide for periodontal services per person per year is **$500.00**

ACCESSING BENEFITS:

Participating Dentists Benefits

Anthem Blue Cross and Blue Shield will pay the lesser of 50% of the dentist's usual charge or 50% of the Usual, Customary and Reasonable Charge, as determined by us, for the dental services described in this Rider. Dentists who participate in our dental programs agree to accept our allowance as full payment and may not bill the member for any additional charges except for the remaining coinsurance balance.

Non-Participating Dentists Benefits

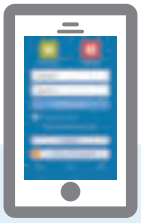
In the event these services are rendered by a non-participating dentist, we will pay to the member the lesser of 50% of the dentist's charge or 50% of the applicable allowance for the procedure as determined by us. The member is responsible for any difference between the amount paid by us and the fee charged by the dentist.

This does not constitute your health plan or insurance policy. It is only a general description for the purposes of this Request for Proposal, of the Anthem Blue Cross and Blue Shield Dental Amendatory Rider C. Refer to your Master Group Policy or Description of Benefits, on file with your employer, for a complete listing of benefits, maximums, exclusions and limitations

Register with anthem.com to access your benefits*

From your computer

- Go to **anthem.com** and select **Register Now**
- Provide the personal information requested
- Create a username and password
- Set your email preferences
- Select **Submit**



From your mobile device

- Search for **Anthem Blue Cross and Blue Shield** in your app store and select Install (It's free). Open the app and select **Register Now**
- Confirm your identity
- Create a username and password
- Set your email preferences
- Confirm and select **Register**

Need help signing up?
Call the Help Desk at **1-866-755-2680.**

Anthem BlueCross BlueShield

* You must be 18 years or older to register your own account.

13206ANMENABS VPOD Rev. 02/15

Choose an easier way to better health

Health and wellness programs designed for your unique needs

Whether you're suffering from asthma, expecting a baby, or just fighting a cold, our health and wellness programs can help. They even include toll-free access to a nurse any time, any day.

Condition Care

If you have a long-term health problem, ConditionCare is for you. It's a program that helps people with asthma, chronic obstructive pulmonary disease (COPD), diabetes, heart failure, coronary artery disease (CAD) and more. When you join the program, we'll give you the tools and resources you need to take charge of your health. You'll also get:

- 24/7 phone access to a nurse care manager who can answer your questions and give you up-to-date information about your condition.
- A health review and follow-up calls if you need them.
- Tips on prevention and lifestyle choices to help you improve your quality of life.

Future Moms

Having a baby is an exciting time! Future Moms can help you have a healthy pregnancy and a healthy baby. Sign up as soon as you know you're pregnant. You'll get:

- 24/7 phone access to a nurse coach you can talk to about your pregnancy and your health. A nurse may also call you from time to time to see how you're doing.
- A book that shows changes you can expect for you and your baby over the next nine months.
- Useful tools to help you, your doctor and your Future Moms nurse coach track your pregnancy and spot possible risks. You'll also get tips and resources to help you make better decisions and prepare for the birth of your baby.

24/7 NurseLine

You can call any time to talk to a registered nurse about your health concerns. You can get answers to questions, whether you're sick or not.

Need health care right away? A nurse can help you decide where to go if your doctor isn't available. Going to the right place can save you time and money. And you can access better care, too.

Get the support you need

Call us to sign up and use these programs at no extra cost:

- ConditionCare: 866-596-9812
- Future Moms: 866-347-8360
- 24/7 NurseLine: 800-711-5947

Anthem BlueCross BlueShield

MCTSH1316A Rev. 1/14

24/7 NurseLine

Always here for your employees – any time, any place
Health concerns don't take vacations or happen only when "the doctor is in." They happen at all hours, during vacations, even during business travel. Sometimes it isn't always clear whether a problem needs medical care. And if it does, choosing the right level of care can be confusing.

24/7 NurseLine gives your employees access to qualified registered nurses anytime. Our nurses help members by answering questions about their health concerns. Whether it's a question about allergies, earaches, types of preventive care or any other topic, answers and support are always there.

Choosing the right level of care can save members time and money, giving them access to the best possible care. The 24/7 NurseLine can help members decide if emergency or urgent care is more appropriate if their doctor isn't available. And 84% of our members agree that 24/7 NurseLine is a trusted resource.[1]

AudioHealth Library
Not everyone wants to talk about their health concerns with someone else. Some people just want to get more information on a health topic. That's why we provide the AudioHealth Library, with more than 300 helpful prerecorded health topics in English and Spanish. It's accessible by phone and, like the 24/7 NurseLine, it's always available.

24/7 NurseLine strives to:

- Help lower health care costs by providing members with health information to help them decide which level of care they may need. Members who use our 24/7 NurseLine are 50% less likely to go to the ER for non-emergency cases.[2]
- Help increase members' satisfaction with their health care plan. Of members surveyed, 85% would recommend 24/7 NurseLine to others.[1]

Anthem BlueCross BlueShield

1 2010 WellPoint Member Satisfaction Survey
2 Anthem Health and Wellness Solutions Internal data, Jan. - Dec. 2008

EANSH1283A Rev. 8/11

Nine months. Many questions.

Future Moms can help — any time, any day

Having a healthy baby is every mom's goal. And it starts with a healthy pregnancy. You want to make the right choices and take care of yourself so you can reach that goal. But it's not always easy to do it alone.

That's why there's Future Moms. It's a program that can answer your questions, help you make good choices and follow your health care provider's plan of care. And it can help you have a safe delivery and a healthy child.

Sign up as soon as you know you're pregnant. Just call us toll free at **866-347-8360**. One of our registered nurses will help you get started. You'll get:

- A toll-free number you can use to talk to a nurse coach any time, any day, about your pregnancy. A nurse may also call you from time to time to see how you're doing.
- A book that shows changes you can expect for you and your baby during the next nine months.
- A screening to check your health risk for depression or early delivery.
- Other useful tools to help you, your doctor and your Future Moms nurse keep track of your pregnancy and help you make healthier choices.
- Free phone calls with pharmacists, nutritionists and other specialists, if needed.
- A booklet with tips to help keep you and your new baby safe and well.
- Other helpful information on labor and delivery, including options and how to prepare.

It's easy to join

Sign up for Future Moms by calling us toll free at **866-347-8360**. There's no extra cost to you.

Anthem BlueCross BlueShield

MCTSH1311A VPOD Rev. 06/14

LiveHealth Online®

Easy, fast doctor visits. All from the comfort of your own computer or mobile device.

Talk to a doctor today, tonight, anytime — 365 days a year.
Just enroll at livehealthonline.com or on the free mobile app.

Anthem BlueCross BlueShield

LiveHealth ONLINE

Now you can get the health care you need without all the hassle

Have a health question? Under the weather? With LiveHealth Online, you don't have to schedule an appointment, drive to the doctor's office, and then wait for your appointment. In fact, you don't even have to leave your home or office. Doctors can answer questions, make a diagnosis, and even prescribe basic medications when needed.*

With LiveHealth Online, you get:

- Immediate doctor visits through live video.
- Your choice of U.S. board-certified doctors.
- Help at a cost that is same as your office visit copay or $49 per visit, subject to deductible and coinsurance, depending on your health plan benefits.
- Private, secure and convenient online visits.

What are the qualifications of the doctors you consult via LiveHealth Online?

- U.S. board-certified.
- Average 15 years practicing medicine.
- Mostly primary care physicians.
- Specially trained for online visits.

When can you use LiveHealth Online?

As always, you should call 911 with any emergency. Otherwise, you can use LiveHealth Online whenever you have a health concern and don't want to wait. Doctors are available 24 hours a day, seven days a week, 365 days a year. Some of the most common uses include:

- Cold and flu symptoms such as a cough, fever and headaches
- Allergies
- Sinus infections
- Family health questions

Start a conversation now.

Just enroll for free at **livehealthonline.com** or on the app, and you're ready to see a doctor.

Not available with HRA plans and plans purchased through the Connecticut Health Insurance Marketplace known as Access Health CT.

Download the app now!

apple.com

play.google.com/store

*As legally permitted in certain states.

Live life to the fullest – without paying full price

Save money with discounts at anthem.com

Saving money is good. Saving money on things that are good for you — that's even better. With SpecialOffers@Anthem℠, you can get discounts on products and services that help promote better health and well-being.* It's just one of the perks of being a member. Check out how much you can save:

Vision and hearing

1-800 CONTACTS® — Get contact lenses quick and easy — plus discounts only available to Anthem members, like $20 off when you spend $100 or more and free shipping.

Glasses.com™ — Get the latest, brand-name frames for just a fraction of the cost at typical retailers — every day. Plus, you get an additional $20 off orders of $100 or more, free shipping and free returns.

Premier LASIK — Save 15% on LASIK with all in-network providers. Prices are as low as $695 per eye with select providers.

Amplifon — Get a low-price guarantee with the seven top companies that work with Amplifon. Save $50 on one hearing aid or $125 on two. Plus, get a three-year repair/loss/damage warranty and a free two-year supply of batteries.

Beltone™ — Get hearing screenings and in-home service at no additional cost, and up to 50% off all Beltone hearing aids.

Fitness and health

Jenny Craig® — Join Jenny Craig and get a 30-day trial at no additional cost and 50% off enrollment.

Lindora® — Save 20% on weight-loss programs.

SelfHelpWorks — Choose one of the online Living programs and get a 40% discount to help you lose weight, stop smoking, manage stress or face an alcohol problem.

GlobalFit™ — Save on gym memberships, home fitness equipment and GlobalFit's Virtual Gym.

ChooseHealthy™ — Get preferred pricing on fitness club memberships and a one-week free trial. Enjoy discounts on acupuncture, chiropractors and massage — plus 40% off certain wellness products.

Performance Bicycle — Get $20 off a purchase of $80 or more in store or online.

Anthem BlueCross BlueShield

Check out more SpecialOffers@Anthem℠ on the other side.

SpecialOffers@Anthem℠ on anthem.com

Family and home

Safe Beginnings® — Babyproof your home while saving 15% on everything from safety gates to outlet covers.

VPI Pet Insurance — Get 5% off pet insurance. Get peace of mind knowing that you have help paying the medical costs for your pet's accidents, illnesses and routine medical care.

ASPCA Pet Health Insurance — Get 5% off pet insurance. You can choose from three levels of care, including flexible deductibles and custom reimbursements.

LinkWell — Get coupons for healthier products.

WINFertility® — Save up to 40% on infertility treatment. WINFertility helps make quality treatment affordable.

LifeMart® — Get great deals on beauty and skin care, diet plans, fitness club memberships and plans, personal care, spa services and yoga classes, sports gear and vision care.

Medicine and treatment

Puritan's Pride — Save 10% and get free shipping on a large selection of vitamins, minerals, herbs, supplements and much more.

Murad® — Save $25 and get a free gift with any purchase of $100 or more on skin care products.

Allergy Control products — Save 25% on Allergy Control encasings for your bed. Plus, save 20% on a variety of doctor-recommended products for a healthier home and enjoy free shipping on orders of $150 or more.

National Allergy® supply — Save 15% on mattress encasings, air filtration products, compressors and other products that can help relieve your allergy, asthma and sinus symptoms.

To find the discounts that are available to you, log in to **anthem.com** and select **Discounts**.

Anthem BlueCross BlueShield

* All discounts are subject to change without notice.

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

Let's talk about your privacy and rights

As a member, you have the right to expect the privacy of your personal health information to be protected, consistent with state and federal laws and our policies. And you also have certain rights and responsibilities when receiving your health care.

To learn more about how we protect your privacy, your rights and responsibilities when receiving health care and your rights under the Women's Health and Cancer Rights Act, go to www.anthem.com/memberrights. To request a printed copy, please contact your Benefits Administrator or Human Resources representative.

How we help manage your care

To decide if we'll cover a treatment, procedure or hospital stay, we use a process called Utilization Management (UM). UM is a program that lets us make sure you're getting the right care at the right time. Licensed health care professionals review information your doctor has sent us to see if the requested care is medically needed. These reviews can be done before, during or after a member's treatment. UM also helps us decide if the services will be covered by your health plan.

We also use case managers. They're 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.

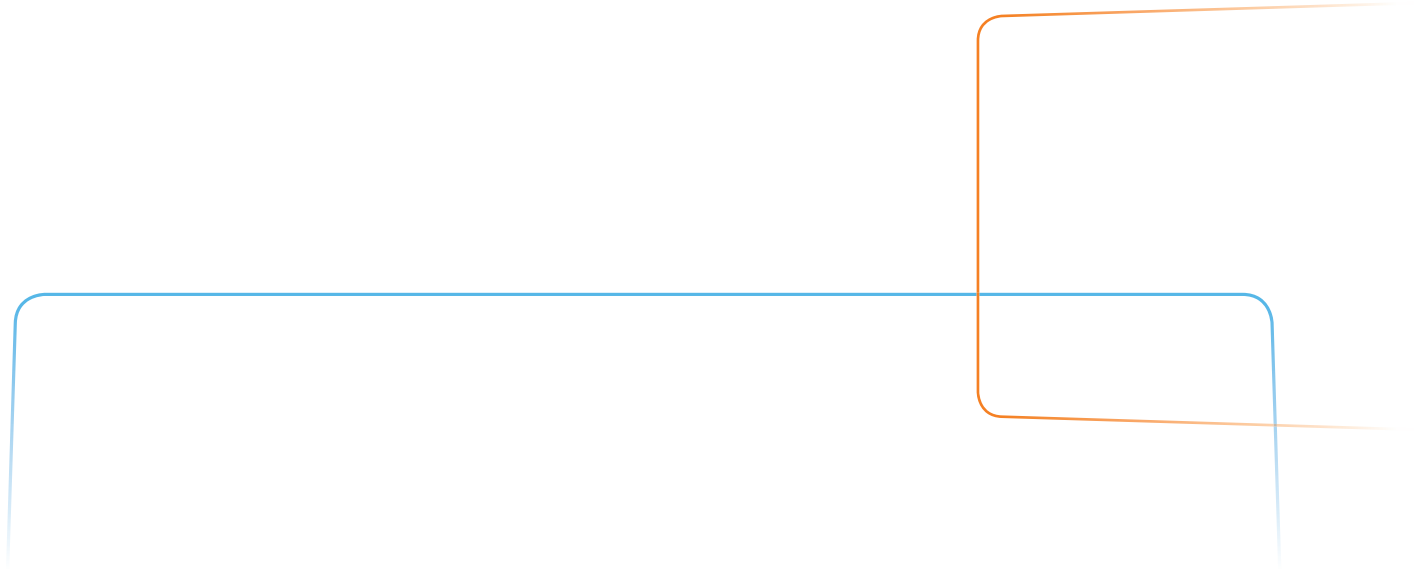
To learn more about how we help manage your care, visit www.anthem.com/memberrights. To request a printed copy, please contact your Benefits Administrator or Human Resources representative.

Special Enrollment Rights

There are certain situations when you can enroll in a plan outside the open enrollment period. Open enrollment usually happens only once a year. That's the time you can enroll in a plan or make changes to it. If you choose not to enroll during open enrollment, there are special cases when you're allowed to enroll yourself and your dependents. Special enrollment is allowed:

- ***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 the employer stops contributing to your health plan), you may be able to enroll with us. You must enroll within 31 days after the other coverage ends (or after the employer stops paying for it).
- For example: 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, may be able to enroll in a plan.
- ***If you have a new dependent.*** This could mean a life event like marriage, birth, adoption or if you have custody of a minor and an adoption is pending. You must enroll within 31 days after the event. For example: If you got married, your new spouse and any new children may be able to enroll in a plan.
- ***If your eligibility for Medicaid or SCHIP changes.*** You have a special period of 60 days to enroll after:
  - You (or your eligible dependents) lose Medicaid or CHIP coverage because you're no longer eligible.
  - You (or eligible dependents) become eligible to get help from Medicaid or SCHIP for paying part of the cost.

Notes



You've got health goals
We've got your back.