Anthem BlueCross

Benefits You Can Count On

University of Southern California
Anthem Blue Cross PPO
PPO Union Benefits
$800 Deductible
Effective January 1, 2012

Choosing the right plan is a very personal thing.

Use this book to find one that's

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

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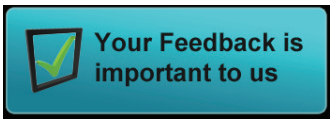
Your Feedback is
important to us

Welcome to Anthem benefits

We're glad you're taking time to check out all that Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company (Anthem) has to offer you. Choosing your benefits is an important decision and this booklet is designed to help. Basically, it's a snapshot of the benefits that come with Anthem coverage. It shows what's available to you, what you get with each benefit and how the plans work.

Explore the Anthem membership advantage.

We know you're busy. That's why we've made sure it only takes a few moments to explore the advantages of being an Anthem member, including:

- There's a good chance your doctor is part of Anthem's network. To find out, go to anthem.com/ca and search the provider directory. We also have one of the largest networks of hospitals and specialists.
- You're covered even when you're away from home. You can travel outside your area or country — and know you're covered.
- You get more than basic coverage. You have access to tools, resources and guidance that may help you reach your personal, healthy best.
- Anthem.com/ca has the answers you need. Simply go to anthem.com/ca for answers to your claims questions and find detailed health benefit information.
- This booklet goes into all this — and more. Please take a few minutes to look over the information, and keep this booklet. It may come in handy.

Registering on anthem.com/ca is step one.

Once you get your ID card, registering is easy; all you need is your ID card, the Internet and five minutes. After you register at anthem.com/ca, you can tap into decision-making tools, health information and many resources. It's also the convenient way to order a new ID card, check claims status, find out the cost of services, learn about doctors and hospitals, and so much more.

- Go to anthem.com/ca
- Enter the site by clicking on Member
- Follow instructions to create your user name and password and you're ready to go!

Read on for information to help you choose your benefits with confidence. If you have any questions, your benefits manager will be happy to answer them. Thanks for considering Anthem.

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How to choose a health care plan that's right for you

Choosing the health care plan that's right for you and your family can be a tough decision. There are so many options and so many words, phrases and abbreviations to learn. And while it can be quite confusing, it's important that you take the time to learn all you can so you can make the best choice to meet your specific needs. The plan you choose will make a difference in how much you spend on your health care during the year. That's why we suggest you take your time to carefully think about your needs and options. And we're here to help.

Ask these questions when choosing a health care plan:

Does the plan:

- Have special programs to help you if you suffer from asthma, diabetes or other ongoing conditions?
- Cover physical exams, shots and health screenings to help you stay healthy and avoid a health problem?
- Give you information such as brochures, newsletters or online tools about healthy living?
- Offer tools to help you manage your health, as well as your benefits?
- Offer discounts on goods and services to improve your health?

Learn about the Anthem Blue Cross difference

At Anthem Blue Cross, we put our members first. We're dedicated to helping them get and stay healthy. Visit anthem.com/ca to learn more about all we have to offer – from our large, strong networks to our personal health programs to the many ways we can help you save money while getting as healthy as possible.

Know the basic differences between the types of plans.

You may have a choice of health care plans at work or within your family. Knowing how the different plans work will help you pick the plan that best fits your family needs and budget.

- **Preferred Provider Organization (PPO)** — gives you coverage for doctors and hospitals that are in-network and out-of-network. This type of plan is different from a POS because you don't need to choose a PCP and you don't need any referrals.

Here are some definitions:

Deductible: The amount you must pay each year before your plan pays anything. There may be a deductible for health care and a separate one for prescription drugs. Not every plan has a yearly deductible.

Coinsurance: An amount that you pay after you have met your plan's deductible. The plan pays a certain amount and you pay a certain amount.

How to choose a health care plan that's right for you (continued)

Copay: The amount that you pay each time you see a doctor, get a prescription filled or get other services. A copay is a flat fee, like $20 for a doctor visit. Most HMOs have co-pays.

Understand the total costs.

Health care plans differ in many ways but with every plan, there's a basic premium, which is how much you and your employer each pay to buy the plan's coverage. The premium may only be a small part of your total cost. There are other payments you may make, which vary by plan. When choosing a plan try to figure out what the total cost is to you and your family, especially if someone in your family has a chronic or serious health condition.

Think about the following:

- Are there deductibles you must pay before the plan begins to help cover your costs?
- Are there office visit, emergency room or inpatient hospital copays?
- What is the coinsurance, meaning what part of the cost for other services do you have to pay out of your own pocket? If you use doctors that are out-of-network, how much more will you have to pay to get care?

To see the types of costs that come with our different health care plans, take a look at the Summary of Benefits. Your benefits manager can get you a copy for each type of plan if you don't already have one.

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Your Health Benefits

PPO Plan

The big buzz these days is that you have the power to take charge of your health. We would agree that's a good idea. That's why we build our health plans with options, resources and overall support to help you make decisions. This is a quick overview of how your plan works.

With no primary doctor requirement and no referrals, you're free to make your own decisions about your health care.

One, you have options. With a PPO plan, you're free to choose your doctor without referrals. Of course, in-network care will usually cost less than out-of-network care. Through the BlueCard® program you have access to nearly 80% of doctors and 90% of hospitals across the nation, so you'll find plenty of choices. The point is, the choice is yours.

Two, as an Anthem member, you have access to a lot of online tools. Helping you make your decisions is important to us, but not nearly as important as helping you make the right decisions — for you, your health and your budget.

PPO at a glance

- *PRIMARY CARE PHYSICIANS (PCPs):* Not required
  You can make your own decisions about your doctors, your care and your costs.
- *REFERRALS:* Not needed
  You have the freedom to choose any licensed provider. However you can receive significant cost savings when you visit a network provider for covered services. You pick who you want to see. Makes getting second opinions very easy.
- *CLAIM FORMS:* No claim forms to submit when using network providers. Network providers will submit claims for you.
- *OUT-OF-NETWORK BENEFITS:* Available, but at lower coverage levels than in-network
  We've negotiated special rates with our network doctors and hospitals on behalf of our members. By staying in-network, you can take advantage of these rates and receive higher levels of coverage.
- *OUT-OF-POCKET:* Common services like office visits, prescriptions and preventive care only require a copay — a fixed dollar amount — and your plan pays the rest. Other than that, most covered services involve deductibles or coinsurance.

You can see what services cost before your visit

Through anthem.com/ca, you can estimate the costs for inpatient and outpatient services and doctor visits. What better way to help you determine what to do?

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PPO Plan (continued)

anthem.com/ca has the answers you need

Simply go to anthem.com/ca for easy access to product, services and health care provider information. And once you get your ID card, register and you can tap into decision-making tools, health information and many resources. It's also the convenient way to order a new ID card, check claims status, find out the cost of services, learn about doctors and hospitals, and so much more.

You're covered whenever you travel

If you're traveling in the U.S. or out of the country, your coverage travels with you. If you need emergency care, get the care you need at the closest emergency facility. If you need urgent or approved follow-up care outside of California you have three ways to find a provider or get the details you need: Go to anthem.com/ca, call BlueCard® Access at 800-810-2583 or call the customer service number on your member ID card.

HOW TO FIND A NETWORK DOCTOR

Anthem networks are some of the largest in California. Simply go online and search our provider directory for the type of care you need.

1. **Go to anthem.com/ca.**
2. **Select "Find a Doctor."**
3. **Select the PPO plan.**
4. **Select your provider type.**
5. **Select a specialist, if needed.**
6. **Enter your search criteria.**
7. **Click "View Results."**

You're getting more than a health plan

You get programs to actually help you manage your health. MyHealth@Anthem®, 360° Health® health management programs, and SpecialOffers@Anthem℠ are all available through anthem.com/ca. The programs are explained in detail later in this booklet.

This is a brief overview of your plan's features. Your summary of benefits contains the details. See your benefits manager if you need a copy. **Welcome to Anthem**.

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2012 USC Hospital Plan Benefits Modified PPO (Prudent Buyer 800/15/80/50)

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. This proposed benefit summary is subject to the approval of the California Department of Insurance and the California Department of Managed Health Care.

In addition to dollar and percentage copays, insureds are responsible for deductibles, as described below. Please review the deductible information to know if a deductible applies to a specific covered service. Certain Covered Services have maximum visit and/or day limits per year. The number of visits and/or days allowed for these services will begin accumulating on the first visit and/or day, regardless of whether your Deductible has been met. Insureds are also responsible for all costs over the plan maximums. Plan maximums and other important information appear in *italics*. Benefits are subject to all terms, conditions, limitations, and exclusions of the Policy.

Explanation of Covered Expense

Plan payments are based on covered expense, which is the lesser of the charges billed by the provider or the following:

PPO Providers—PPO negotiated rates. Insureds are not responsible for the difference between the provider's usual charges & the negotiated amount.

Non-PPO Providers—For non-emergency services, the scheduled amount. For emergency services, same as other health care providers

Other Health Care Providers *(includes those not represented in the PPO provider network)*—The customary & reasonable charge for professional services or the reasonable charge for institutional services.

When using Non-PPO and Other Health Care Providers, Insureds are responsible for any difference between the covered expense & actual charges, as well as any deductible & percentage copay.

Calendar year deductible for all providers 800 Plan High Option	PPO $800/Insured/$1,600 family; Non-PPO $2,400/Insured/$4,800 family;
Deductible for non-Anthem Blue Cross PPO hospital or residential treatment center	$500/admission *(waived for emergency admission)*
Deductible for non-Anthem Blue Cross PPO ASC or Outpatient hospital	$150/admission *(waived for emergency admission)*
Deductible for hospital or residential treatment center if utilization review not obtained	**PPO** $250/admission *(waived for emergency admission)* **Non-PPO** $500/admission *(waived for emergency admission)*
Deductible for emergency room services	$100/visit *(waived if admitted directly from ER)*
Annual Out-of-Pocket Maximums	
USC/PPO Providers & Other Health Care Providers **800 Plan Low Option**	$3,200/Insured/$9,600 family
Non-PPO Providers	No Maximum

The following do not apply to out-of-pocket maximums: deductibles listed above; and non-covered expense. After an Insured reaches the out-of-pocket maximum, the Insured remains responsible for deductibles listed above: for non-PPO providers & other health care providers, costs in excess of the covered expense; amounts related to a transplant unrelated donor search.

Lifetime Maximum	Unlimited/Insured		
Covered Services	**USC PPO Insured Copay**	**PPO: Per Insured Copay**	**Non-PPO: Per Insured Copay**
Hospital Medical Services *(subject to utilization review for inpatient services; waived for emergency admissions)*			
➢ Semi-private room, meals & special diets, & ancillary services	20% (deductible waived)	40%	50%[1]
➢ Outpatient medical care, surgical services & supplies *(hospital care other than emergency room care)*	20% (deductible waived)	40%	50%[1]
Ambulatory Surgical Centers			
➢ Outpatient surgery, services & supplies	20%	40%	50%
Hospice Care			
➢ Inpatient or outpatient services; family bereavement services	20% (deductible waived)	20%[2]	20%[2]

[1] For California facilities, a discount applies if the facility has a contract with Anthem Blue Cross Life and Health Insurance Company for fee-for-service business. For California facilities without a contract, covered expense for non-emergency hospital services and supplies is reduced by 25%, resulting in higher out-of-pocket costs for Insureds.

[2] These providers are not represented in the Anthem Blue Cross Life and Health Insurance Company PPO network.

Covered Services	PPO: Per Insured Copay	Non-PPO: Per Insured Copay
Skilled Nursing Facility *(subject to utilization review)*		
➢ Semi-private room, services & supplies *(limited to100 days/calendar year combined in and out of network including residential treatment centers)*	20%	50%
Home Health Care *(subject to utilization review)*		
➢ Services & supplies from a home health agency *(limited to 100 visits/calendar year, one visit by a home health aide equals four hours or less; not covered while Insured receives hospice care)*	20%	50%
Home Infusion Therapy *(subject to utilization review)*		
➢ Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	20%	50% *(benefit limited to $600/day)*
Physician Medical Services		
➢ Office & home visits	20%	50%
➢ Hospital & skilled nursing facility visits	20%	50%
➢ Surgeon & surgical assistant; anesthesiologist or anesthetist	20%	50%
Diagnostic X-ray & Lab		
➢ MRI, CT scan, PET scan & nuclear cardiac scan *(subject to utilization review)*	20%	50%
➢ Other diagnostic x-ray & lab	20%	50%
Preventive Care Services *Preventive Care Services that meet the requirements of federal and state law, including certain screenings, immunizations and physician visits*		
➢ Routine physical examinations *(birth through age six)*	No copay/exam *(deductible waived)*	50%
➢ Immunizations *(birth through age six)*	No copay *(deductible waived)*	50%
➢ Routine physical exams, immunizations, diagnostic X-ray & lab for routine physical exam *(insureds 7 years old and older)*	No copay/exam *(deductible waived)*	Not covered
➢ Adult preventive services *(including mammograms, pap smears, prostate cancer screenings & colorectal cancer screenings)*	No copay *(deductible waived)*	50% *(deductible waived)*
Physical Therapy, Physical Medicine & Occupational Therapy, including Speech Therapy	20%	50%
Chiropractic Services		
➢ Services for the treatment of disease, illness or injury	20%	50%
Acupuncture		
➢ Services for the treatment of disease, illness or injury	20%[2]	50%[2]
Temporomandibular Joint Disorders		
➢ Splint therapy & surgical treatment	20%	50%
Pregnancy & Maternity Care		
➢ Physician office visits	20%	50%
➢ Prescription drug for elective abortion *(mifepristone)*	20%	50%
Normal delivery, cesarean section, complications of pregnancy & abortion *(newborn routine nursery care covered when natural mother is subscriber or spouse/domestic partner)*		
➢ Inpatient physician services	20%	50%
➢ Hospital & ancillary services	20%	50%
Organ & Tissue Transplants *(subject to utilization review; specified organ transplants covered only when performed at Centers of Medical Excellence [CME])*		
➢ Inpatient services provided in connection with non-investigative organ or tissue transplants	20%	

[1] The dollar copay applies only to the visit itself. An additional 20% copay applies for any services performed in office (i.e., X-ray, lab, surgery), after any applicable deductible.

[2] Acupuncture services can be performed by a certified acupuncturist (C.A.), a doctor of medicine (M.D.), a doctor of osteopathy (D.O.), a podiatrist (D.P.M.), or a dentist (D.D.S.).

Covered Services	PPO: Per Insured Copay	Non-PPO: Per Insured Copay
Organ & Tissue Transplants (continued)		
➢ Transplant travel expense for an authorized, specified transplant at a CME *(recipient & companion transportation limited to 6 trips/episode & $250/person/trip for round-trip coach airfare, hotel limited to 1 room double occupancy & $100/day for 21 days/trip, other expenses limited to $25/day/person for 21 days/trip; donor transportation limited to 1 trip/episode & $250 for round-trip coach airfare, hotel limited to $100/day for 7 days, other expenses limited to $25/day for 7 days)*	No copay *(deductible waived)*	
Bariatric Surgery *(subject to utilization review; medically necessary surgery for weight loss, only for morbid obesity, covered only when performed at Centers of Medical Excellence [CME])*		
➢ Inpatient services provided in connection with medically necessary surgery for weight loss, only for morbid obesity	10%	
➢ Bariatric travel expense when member's home is 50 miles or more from the nearest Bariatric *CME (member's transportation to & from CME limited to $130/person/trip for 3 trips [pre-surgical visit, initial surgery & one follow-up visit]; one companion's transportation to & from CME limited to $130/person/trip for 2 trips [initial surgery & one follow-up visit]; hotel for member & one companion limited to one room double occupancy & $100/day for 2 days/trip, or as medically necessary, for pre-surgical & follow-up visit; hotel for one companion limited to one room double occupancy & $100/day for duration of member's initial surgery stay for 4 days; other reasonable expenses limited to $25/day/person for 4 days/trip)*	No copay *(deductible waived)*	
Diabetes Education Programs *(requires physician supervision)*		
➢ Teach Insured & their families about the disease process, the daily management of diabetic therapy & self-management training	20% *(deductible waived)*	50%
Prosthetic Devices		
➢ Coverage for breast prostheses; prosthetic devices to restore a method of speaking; surgical implants; artificial limbs or eyes; the first pair of contact lenses or eyeglasses when required as a result of eye surgery; & therapeutic shoes & inserts for Insured with diabetes	20%	50%
Durable Medical Equipment		
➢ Rental or purchase of DME including hearing aids, dialysis equipment & supplies *(hearing aids benefit available for one hearing aid per ear every three years)*	20%	50%
Related Outpatient Medical Services & Supplies		
➢ Ground or air ambulance transportation, services & disposable supplies	20%[1]	
➢ Blood transfusions, blood processing & the cost of unreplaced blood & blood products	20%[1]	
➢ Autologous blood *(self-donated blood collection, testing, processing & storage for planned surgery)*	20%[1]	
Specialty Pharmacy Drugs *(utilization review may be required)*		
➢ Specialty pharmacy drugs filled through the specialty pharmacy program *(limited to 30-day supply; not covered if benefits are provided through prescription drug benefits, if applicable)*	20%	Not covered[2]
If Insured does not get specialty pharmacy drugs from the specialty pharmacy program, Insured will not receive any specialty pharmacy drug benefits under this plan, unless the Insured qualifies for an exception as specified in the Certificate.		

[1] These providers are not represented in the Anthem Blue Cross Life and Health Insurance Company PPO network.

[2] 20% copay if Insured or non-PPO physician obtains drug from Specialty Pharmacy Program; otherwise, not covered.

Covered Services	PPO: Per Insured Copay	Non-PPO: Per Insured Copay
Emergency Care		
➢ Emergency room services & supplies *($100 deductible waived if admitted)*	10%	10%
➢ Inpatient hospital services & supplies	10%	10%
➢ Physician services	10%	10%
Mental or Nervous Disorders and Substance Abuse		
Inpatient Care		
➢ Facility-based care *(subject to utilization review; waived for emergency admission each inpatient day maybe be substituted for two one-half days of outpatient treatment)*	20% *(deductible waived)*	50%
➢ Inpatient physician visits	20%	50%
Outpatient Care		
➢ Facility-based care *(subject to utilization review; waived for emergency admissions)*	20%	50%
➢ Outpatient physician visits *(pre-service review required after the 12th visit)*	20%	50%

[1] For California facilities, a discount applies if the facility has a contract with Anthem Blue Cross Life and Health Insurance Company for fee-for-service business. For California facilities without a contract, covered expense for non-emergency hospital services and supplies is reduced by 25%, resulting in higher out-of-pocket costs for Insureds.

This Summary of Benefits is a brief review of benefits. Once enrolled, Insureds will receive a Combined Certificate and Disclosure Form, which explains the exclusions and limitations, as well as the full range of covered services of the plan, in detail.

PPO—Prudent Buyer Plan Exclusions and Limitations

Not Medically Necessary. Services or supplies that are not medically necessary, as defined.

Experimental or Investigative. Any experimental or investigative procedure or medication. But, if Insured is denied benefits because it is determined that the requested treatment is experimental or investigative, the Insured may request an independent medical review, as described in the Certificate.

Outside the United States. Services or supplies furnished and billed by a provider outside the United States, unless such services or supplies are furnished in connection with urgent care or an emergency.

Crime or Nuclear Energy. Conditions that result from (1) the Insured's commission of or attempt to commit a felony, as long as any injuries are not a result of a medical condition or an act of domestic violence; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available for the treatment of illness or injury arising from the release of nuclear energy.

Not Covered. Services received before the Insured's effective date. Services received after the Insured's coverage ends, except as specified as covered in the Certificate.

Excess Amounts. Any amounts in excess of covered expense or the lifetime maximum.

Work-Related. Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, whether or not the Insured claims those benefits. If there is a dispute of substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers' compensation, we will provide the benefits of this plan for such conditions, subject to a right of recovery and reimbursement under California Labor Code Section 4903, as specified as covered in the Certificate.

Government Treatment. Any services the Insured actually received that were provided by a local, state or federal government agency, except when payment under this plan is expressly required by federal or state law. We will not cover payment for these services if the Insured is not required to pay for them or they are given to the insured person for free.

Services of Relatives. Professional services received from a person living in the Insured's home or who is related to the Insured by blood or marriage, except as specified as covered in the Certificate.

Voluntary Payment. Services for which the Insured has no legal obligation to pay, or for which no charge would be made in the absence of insurance coverage or other health plan coverage, except services received at a non-governmental charitable research hospital. Such a hospital must meet the following guidelines:

1. it must be internationally known as being devoted mainly to medical research;
2. at least 10% of its yearly budget must be spent on research not directly related to patient care;
3. at least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;
4. it must accept patients who are unable to pay; and
5. two-thirds of its patients must have conditions directly related to the hospital's research.

Not Specifically Listed. Services not specifically listed in the plan as covered services.

Private Contracts. Services or supplies provided pursuant to a private contract between the Insured and a provider, for which reimbursement under Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

Inpatient Diagnostic Tests. Inpatient room and board charges in connection with a hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.

Mental or Nervous Disorders. Academic or educational testing, counseling, and remediation. Mental or nervous disorders or substance abuse, including rehabilitative care in relation to these conditions, except as specified as covered in the Certificate.

Nicotine Use. Smoking cessation programs or treatment of nicotine or tobacco use. Smoking cessation drugs

Orthodontia. Braces, other orthodontic appliances or orthodontic services.

Dental Services or Supplies. Dental plates, bridges, crowns, caps or other dental prostheses, dental implants, dental services, extraction of teeth, treatment to the teeth or gums, or treatment to or for any disorders for the temporomandibular (jaw) joint, except as specified as covered in the Certificate. Cosmetic dental surgery or other dental services for beautification.

Hearing Aids or Tests. Hearing aids and routine hearing tests, except as specified as covered in the Certificate.

Optometric Services or Supplies. Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, as specified as covered in the Certificate. Eyeglasses or contact lenses, except as specified as covered in the Certificate.

Outpatient Occupational Therapy. Outpatient occupational therapy, except by a home health agency, hospice, or home infusion therapy provider, as specified as covered in the Certificate.

Outpatient Speech Therapy. Outpatient speech therapy, except as specified as covered in the Certificate.

Cosmetic Surgery. Cosmetic surgery or other services performed solely for beautification or to alter or reshape normal (including aged) structures or tissues of the body to improve appearance. This exclusion does not apply to reconstructive surgery (that is, surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or to create a normal appearance), including surgery performed to restore symmetry following mastectomy. Cosmetic surgery does not become reconstructive surgery because of psychological or psychiatric reasons.

Weight Alteration Programs (Inpatient and Outpatient). Weight loss or weight gain programs including, but not limited to, dietary evaluations and counseling, exercise programs, behavioral modification programs, surgery, laboratory tests, food and food supplements, vitamins and other nutritional supplements associated with weight loss or weight gain. Dietary evaluations and counseling, and behavioral modification programs are covered for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity is covered, except as specified as covered in the Certificate.

Sex Transformation. Procedures or treatments to change characteristics of the body to those of the opposite sex.

Sterilization Reversal.

Infertility Treatment. Any services or supplies furnished in connection with the diagnosis and treatment of infertility, including, but not limited to diagnostic tests, medication, surgery, artificial insemination, in vitro fertilization, sterilization reversal and gamete intrafallopian transfer.

Orthopedic Supplies. Orthopedic supplies, orthopedic shoes (other than shoes joined to braces), or non-custom molded and cast shoe inserts, except for therapeutic shoes and inserts for the prevention and treatment of diabetes-related feet complications as specified as covered in the Certificate.

Air Conditioners. Air purifiers, air conditioners or humidifiers.

Custodial Care or Rest Cures. Inpatient room and board charges in connection with a hospital stay primarily for environmental change or physical therapy. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a skilled nursing facility or custodial care or rest cures, except as specified as covered in the Certificate.

Chronic Pain. Treatment of chronic pain, except as specified as covered in the Certificate.

Exercise Equipment. Exercise equipment or any charges for activities, instrumentalities or facilities normally intended or used for developing or maintaining physical fitness including, but not limited to, charges from a physical fitness instructor, or health club or gym, even if ordered by a physician.

Personal Items. Any supplies for comfort, hygiene or beautification.

Education or Counseling. Educational services or nutritional counseling, except as specified as covered in the Certificate. This exclusion does not apply to counseling for the treatment of anorexia nervosa or bulimia nervosa.

Food or Dietary Supplements. Food or dietary supplements, except as specified as covered in the Certificate.

Telephone and Facsimile Machine Consultations. Consultations provided by telephone or facsimile machine.

Routine Exams or Tests. Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority, except as specified as covered in the Certificate.

Acupuncture. Acupuncture treatment, except as specified as covered in the Certificate. Acupressure or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatomes or acupuncture points.

Eye Surgery for Refractive Defects. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery.

Physical Therapy or Physical Medicine. Services of a physician for physical therapy or physical medicine, except when provided during a covered inpatient confinement or as specified as covered in the Certificate.

Outpatient Prescription Drugs and Medications. Outpatient prescription drugs or medications and insulin, except as specified as covered in the Certificate. Any non-prescription, over-the-counter patent or proprietary drug or medicine. Cosmetics, health or beauty aids.

Specialty Pharmacy Drugs. Specialty pharmacy drugs that must be obtained from the specialty pharmacy program, but, which are obtained from a retail pharmacy, are not covered by this plan. **Insured will have to pay the full cost of the specialty pharmacy drugs obtained from a retail pharmacy that should have been obtained from the specialty pharmacy program.**

Contraceptive Devices. Contraceptive devices prescribed for birth control except as specified as covered in the Certificate.

Diabetic Supplies. Prescription and non-prescription diabetic supplies except as specified as covered in the Certificate.

Private Duty Nursing. Inpatient or outpatient services of a private duty nurse.

Lifestyle Programs. Programs to alter one's lifestyle which may include but are not limited to diet, exercise, imagery or nutrition. This exclusion will not apply to cardiac rehabilitation programs approved by us.

Wigs.

Pre-Existing Condition Exclusion – No payment will be made for services or supplies for the treatment of a pre-existing condition during a period of six months following either: (a) the Insured's effective date or (b) the first day of any waiting period required by the group, whichever is earlier. However, this limitation does not apply to a child born to or newly adopted by an enrolled subscriber or spouse/domestic partner, or to conditions of pregnancy. Also if a Insured was covered under creditable coverage, as outlined in the Insured's Certificate, the time spent under the creditable coverage will be used to satisfy, or partially satisfy, the six-month period.

Third Party Liability – Anthem Blue Cross Life and Health Insurance Company is entitled to reimbursement of benefits paid if the Insured recovers damages from a legally liable third party.

Coordination of Benefits – The benefits of this plan may be reduced if the Insured has any other group health or dental coverage so that the services received from all group coverages do not exceed 100% of the covered expense.

2012 USC Hospital Plan Modified PPO

Modified Rx 18 Prescription Drug Benefits

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. This proposed benefit summary is subject to the approval of the California Department of Insurance and the California Department of Managed Health Care.

PLEASE NOTE*: This is only a summary of your benefits. Please refer to your Combined Evidence of Coverage and Disclosure Form ("EOC")/Certificate of Insurance ("Certificate") which explains your plan's Exclusions and Limitations as well as the full range of your covered services in detail.*

At Anthem Blue Cross, we know that prescription drugs are the fastest–rising item of your total health care benefits cost. The reasons for the spiraling costs of prescription drugs are varied and include: a general increase of prescription medication use, an aging population, research and development of new medications and the expense of direct to consumer advertising. With prescription drug costs increasing at twice the rate of medical care, we developed ways to contain costs so your copays remain affordable, while maintaining your access to safe, effective prescription drugs. Our Prescription Drug Program provides you with choice, flexibility, affordability and access to an extensive network of retail pharmacies.

Getting a Prescription Filled at a Participating Pharmacy
To get a prescription filled, you need only take your prescription to a participating pharmacy and present your member ID card. The amount you pay for a covered prescription – your copay – will be determined by the drug's type (whether the drug is a brand-name or generic medication and whether it is a formulary or non-formulary medication).

A generic drug contains the same effective ingredients, meets the same standards of purity as its brand-name counterpart and typically costs less. In many situations, you have a choice of filling your prescription with a generic medication or a brand-name medication.

The formulary is a list of approximately 600 recommended brand and generic medications. These medications have undergone extensive review for therapeutic value for a particular medical condition, safety and cost. Copies of our formulary are furnished to your providers and are available online at anthem.com/ca under the Pharmacy section. You or your provider may also contact our Pharmacy Customer Service at 800-700-2541.

The following chart summarizes the relation between drug type and your copay amount at a participating pharmacy:

Drug Type	Copay Amount
Deductible	$25.00
Generic	$10.00
Brand name formulary	$25.00
Brand name non-formulary	$40.00

Finding a Participating Pharmacy
Because our huge pharmacy network includes major drugstore chains plus a wide variety of independent pharmacies, it is easy for you to find a participating pharmacy. You can also find a participating pharmacy by calling Pharmacy Customer Service at 800-700-2541 or by going to our Web site at anthem.com/ca.

An Extensive Network
Besides saving you money, our extensive network of pharmacies offers you easy accessibility.

- In California there are over 5,100 retail pharmacies. This accounts for nearly 95% of retail pharmacies in the state, including all major chains.
- Nationwide there are more than 61,000 chain and independent pharmacies.

Using a Participating Pharmacy
You can substantially control the cost of your prescription drugs by using our extensive network of participating pharmacies. Participating pharmacies have agreed to charge you not more than the prescription drug maximum allowed amount.

Using a Non-Participating Pharmacy
If you choose to fill your prescription at a non-participating pharmacy, your costs will increase. You will likely need to pay for the entire amount of the prescription and then submit a prescription drug claim form for reimbursement. If you do not have the original pharmacy receipt(s) showing the date filled, name and address of the pharmacy, doctor's name, NDC number, name of drug and strength, quantity and days supply, prescription number, and the amount paid, the pharmacist must sign and complete the appropriate section of the claim form to ensure proper processing of the claim for reimbursement.

Members that submit claims from non-participating pharmacies are reimbursed based on a **prescription drug maximum allowed amount**. The prescription drug maximum allowed amount may be considerably less than you paid for your medication. You are responsible for any difference in cost between the prescription drug maximum allowed amount and what you paid for your medication.

The following chart illustrates potential increased out-of-pocket expenses for going to a non-participating pharmacy:

	Out-of-pocket costs using a participating pharmacy	**Out-of-pocket costs using a non-participating pharmacy**
Pharmacy's normal charge for brand-name formulary drug	$50.00	$50.00
You are responsible for:	$25.00 copay	$25 copay plus 50% of the limited fee schedule plus any amounts exceeding the fee schedule
Total out-of-pocket expenses	**$25.00**	**Expense varies based on the cost of the medication**

You may obtain a prescription drug claim form by calling Pharmacy Customer Service at the toll-free number printed on your member ID card or by going to our Web site at anthem.com/ca.

Submitting a Claim Form
Check to see that all sections of the claim form are completed and mail to:

Anthem Blue Cross Prescription Drug Program
Attn: Anthem Blue Cross
P.O. Box 145433
Cincinnati, OH 45250-5433

Mail Service Prescription Drug Program
If you take a prescription drug on a regular basis, you may want to take advantage of our mail service program. Ordering your medications by mail is convenient, saves time and depending on your plan design, may even save you money. Besides enjoying the convenience of home delivery, you will also receive a greater supply of medications. To fill a prescription through the mail, simply complete the Mail Service Prescription form. You may obtain the form by calling Customer Service, at the toll-free number listed on your ID card or by going to our Web site at anthem.com/ca.

Once you complete the form, simply mail it with your copay and prescription in the envelope attached to the Mail Service brochure.

Please note that not all medications are available through the Mail Service Program. Specialty pharmacy drugs are not available through the mail service program, see Specialty Pharmacy Program below.

Out-Of-State Prescription Benefits
Our national network of participating pharmacies is available to members when outside California. To find a participating pharmacy, a member can check our Web site or call the toll-free number printed on the ID card. When using a non-participating pharmacy outside of California, the member will follow the same procedures for using a non-participating pharmacy in California as outlined above.

Additional Features That are Part of your Plan

Prior authorization as the term implies, means some drugs require prior authorization before you can get them (this is similar to prior authorization for medical services). Prior authorization applies to a certain medications that are often a second line of therapy. To receive prior authorization, you must meet specific criteria. The criteria will be based on medical policy and the pharmacy and therapeutics established guidelines. You may need to try a drug other than the one originally prescribed if we determine that it should be clinically effective for you. Drugs which require prior authorization are not covered unless you receive a prior approval from Anthem Blue Cross.

In order for you to get a drug which requires prior authorization, your physician needs to make a written request to us for you. We distribute instructions on how to obtain prior authorization to physicians and pharmacies so that you may obtain prior authorization for required medications. You may call Pharmacy Customer Service, at the toll-free number printed on your member ID card, to receive a prior authorization form and/or list of medications requiring prior authorization.

Supply limits are the proper FDA recommendations for prescription medication dosage coupled with our determination of specific quantity supply limits to prescription medications. Although our standard pharmacy plans offer a 30-day supply for medications at a retail pharmacy, the supply limit can vary based on the medication, dosage and usage prescribed by your physician. For example, the supply limit for antibiotics used to treat an infection (e.g., 14 pills to be taken twice a day for one week) is different than blood pressure medication taken on a routine basis (e.g., 120 pills to be taken twice a day for 60 days). By adhering to specified supply limits, members are assured of receiving the appropriate amount of medication.

Specialty Pharmacy Program
Specialty medications are usually dispensed as an injectable drug, but may be available in other forms, such as a pill or inhalant. They are used to treat complex conditions. Prescriptions for a specialty pharmacy drug are covered only when ordered through the specialty pharmacy program unless you are given an exception from the specialty drug program (see your EOC/Certificate for details). The specialty pharmacy program will deliver your medication to you by mail or common carrier (you cannot pick up your medication).

You may have to pay the full cost of a specialty pharmacy drug if it is not obtained from the specialty pharmacy program.

Specialty drugs are limited to a 30-day supply for each fill.

Programs for Member's Special Health Needs
We recognize that some of our members have unique health care needs requiring special attention. That's why we developed programs exclusively for them. Our additional medical management programs work in synergy with our pharmacy drug program to help members better manage their health care on an ongoing basis.

Diabetic members can receive **free glucometers** so that they can effectively and conveniently monitor their glucose levels.

Seniors can better monitor their chronic diseases and multiple medications through our **seniors-at-risk program.** This program reduces the possibility of toxic drug interactions**,** and curtails distribution of medications that may adversely affect the senior's chronic condition.

Asthmatic members and their families can take advantage of our program to better control the frequency and severity of the disease.

Members who take multiple prescription medications can take advantage of our pharmacy utilization management programs that encourage the safe, effective distribution of prescription medications. We have a program that protects the welfare of members with multiple prescription medications by carefully monitoring their prescription therapy to help reduce the danger of toxic drug interaction.

For additional information regarding your prescription drug benefits, please call Pharmacy Customer Service at the toll-free number printed on your member ID card.

Covered Services (outpatient prescriptions only)	Per Member Copay for Each Prescription or Refill
Retail Pharmacy	
➢ Deductible Per Member	$25
➢ Generic drugs	$10
➢ Brand name formulary drugs	$25
➢ Brand name non-formulary drugs[1]	$40
➢ Self-administered injectable drugs, except insulin	20% of prescription drug covered expenses *(maximum $100 copay)*
Mail Service	
➢ Deductible Per Member	None
➢ Generic drugs	$25
➢ Brand name formulary drugs	$63
➢ Brand name non-formulary drugs[1]	$100
➢ Self-administered injectable drugs, except insulin	20% of prescription drug covered expenses *(maximum $300 copay)*
Specialty Pharmacy Drugs *(obtained through specialty pharmacy program)*	
➢ Deductible Per Member	$25
➢ Generic drugs	$10
➢ Brand name drugs	$25
➢ Brand name non-formulary drugs[1]	$40
➢ Self-administered injectable drugs, except insulin	20% of prescription drug covered expenses *(maximum $100 copay)*
Non-participating Pharmacies *(compound drugs & specialty pharmacy drugs not covered)*	*Member pays the above copay plus:* 50% of the remaining prescription drug covered expense & costs in excess of the maximum amount allowed
Supply Limits[2]	
➢ Retail Pharmacy *(participating and non-participating)*	30-day supply; 60-day supply for federally classified Schedule II attention deficit disorder drugs that require a triplicate prescription form, but require a double copay; 6 tablets or units/30-day period for impotence and/or sexual dysfunction drugs (available only at retail pharmacies)
➢ Mail Service	90-day supply
➢ Specialty Pharmacy	30-day supply

[1] When the member's physician has specified "dispense as written" (DAW) for non-formulary drugs, the copay for brand name formulary drugs will apply. When the member's physician has not specified DAW for non-formulary drugs, the higher copay will apply.

[2] Supply limits for certain drugs may be different. Please refer to the Evidence of Coverage and Disclosure form (EOC) for complete information.

The Prescription Drug Benefit covers the following:

- Outpatient prescription drugs and medications which the law restricts to sale by prescription. Formulas prescribed by a physician for the treatment of phenylketonuria. These formulas are subject to the copay for brand name drugs.
- Insulin
- Syringes when dispensed for use with insulin and other self-injectable drugs or medications
- Prescription oral contraceptives; contraceptive diaphragms. Contraceptive diaphragms are limited to one per year and are subject to the brand name copay.
- Injectable drugs which are self-administered by the subcutaneous route (under the skin) by the patient or family member. Drugs that have Food and Drug Administration (FDA) labeling for self-administration
- All compound prescription drugs that contain at least one covered prescription ingredient
- Diabetic supplies (i.e., test strips and lancets)
- Prescription drugs for treatment of impotence and/or sexual dysfunction are limited to organic (non-psychological) causes.
- Inhaler spacers and peak flow meters for the treatment of pediatric asthma. These items are subject to the copay for brand name drugs.
- Certain over-the-counter drugs approved by the Pharmacy and Therapeutics Committee to be included in the prescription drug formulary.

Prescription drug copays are separate from the medical copays of the medical plan and are not applied toward the Annual Out-of-Pocket Maximums.

Prescription Drug Exclusions & Limitations

Immunizing agents, biological sera, blood, blood products or blood plasma

Hypodermic syringes &/or needles, except when dispensed for use with insulin & other self-injectable drugs or medications

Drugs & medications used to induce spontaneous & non-spontaneous abortions

Drugs & medications dispensed or administered in an outpatient setting, including outpatient hospital facilities and physicians' offices

Professional charges in connection with administering, injecting or dispensing drugs

Drugs & medications that may be obtained without a physician's written prescription, except insulin or niacin for cholesterol lowering and certain over-the-counter drugs approved by the Pharmacy and Therapeutics Committee to be included in the prescription drug formulary.

Drugs & medications dispensed by or while confined in a hospital, skilled nursing facility, rest home, sanatorium, convalescent hospital or similar facility

Durable medical equipment, devices, appliances & supplies, even if prescribed by a physician, except contraceptive diaphragms, as specified as covered in the EOC/Certificate

Services or supplies for which the member is not charged

Oxygen

Cosmetics & health or beauty aids. However, health aids that are medically necessary and meet the requirements as specified as covered in the EOC/Certificate.

Drugs labeled "Caution, Limited by Federal Law to Investigational Use," or experimental drugs. Drugs or medications prescribed for experimental indications

Any expense for a drug or medication incurred in excess of the prescription drug maximum allowed amount.

Drugs which have not been approved for general use by the State of California Department of Health or the Food and Drug Administration. This does not apply to drugs that are medically necessary for a covered condition.

Drugs to eliminate or reduce dependency on, or addiction to, tobacco and tobacco products. This does not apply to medically necessary drugs that the member can only get with a prescription under state and federal law.

Drugs used primarily for cosmetic purposes (e.g., Retin-A for wrinkles). However, this will not apply to the use of this type of drug for medically necessary treatment of a medical condition other than one that is cosmetic.

Drugs used primarily to treat infertility (including, but not limited to, Clomid, Pergonal and Metrodin), unless medically necessary for another condition.

Anorexiants and drugs used for weight loss, except when used to treat morbid obesity (e.g., diet pills & appetite suppressants)

Drugs obtained outside the U.S, unless they are furnished in connection with urgent care or an emergency.

Allergy desensitization products or allergy serum

Infusion drugs, except drugs that are self-administered subcutaneously

Herbal supplements, nutritional and dietary supplements except for formulas for the treatment of phenylketonuria.

Prescription drugs with a non-prescription (over-the-counter) chemical and dose equivalent except insulin. This does not apply if an over-the-counter equivalent was tried and was ineffective.

Compound medications unless:

a. There is at least one component in it that is a prescription drug; and
b. It is obtained from a participating pharmacy. **Member will have to pay the full cost of the compound medications if member obtains drug at a non-participating pharmacy.**

Specialty pharmacy drugs that must be obtained from the specialty pharmacy program, but which are obtained from a retail pharmacy are not covered by this plan. **Member will have to pay the full cost of the specialty pharmacy drugs obtained from a retail pharmacy that member should have obtained from the specialty pharmacy program.**

Third Party Liability

Anthem Blue Cross Life and Health Insurance Company is entitled to reimbursement of benefits paid if the member recovers damages from a legally liable third party.

Your prescription drug plan

Retail pharmacy network

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

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

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

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

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

Home Delivery Pharmacy

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

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

Note about your pharmacy information on the web:

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

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

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Your prescription drug plan (continued)

Getting started with home delivery

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

By phone: Call **866-297-1013**, Monday through Friday, 8:30 a.m. to 8 p.m., Eastern time. You'll find out how much your prescription will cost and how much you can save. Have this information handy: your prescription, doctor's name, phone number, drug names and strengths and credit card (cardholder name, account number and expiration date).

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

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

  Home Delivery Pharmacy
  PO Box 66558
  St. Louis, MO 63166-6558

By fax: Have your doctor fax your prescription to **866-272-8856**. It must be faxed directly from your doctor's office. If there is a question about your prescription, the pharmacy will contact your doctor.

Ordering refills

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

By phone: Have your prescription label and credit card ready. Call **866-297-1013** and select "Automated Refill Order Line" from the menu. Or press zero any time to speak with a patient care advocate. If you are speech or hearing impaired, call **800-899-2114**. Follow the prompts to place your order.

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

Home Delivery Pharmacy
PO Box 66558
St. Louis, MO 63166-6558

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Your prescription drug plan (continued)

Online: Visit **anthem.com/ca**.

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

Specialty pharmacy

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

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

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

Ordering specialty drugs

You can place your first order by phone or fax.

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

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

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Your prescription drug plan (continued)

Ordering refills

Online: Visit **anthem.com/ca**.

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

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

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

Drug List

Our Drug List (sometimes called a formulary) is a list of prescription drugs covered by your plan. It's made up of hundreds of brand and generic drugs.

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

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

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

Generic drugs

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

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

Your prescription drug plan (continued)

Why generics cost less

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

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

Prior authorization

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

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

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

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

EXPRESS SCRIPTS®

HOME DELIVERY PHARMACY ORDER FORM

To MAIL your prescription:
1. "Patient" box must be filled out.
2. Have your Doctor write a prescription.
3. Send your new prescription along with this completed form to:
   Express Scripts Home Delivery Service
   PO Box 66558
   St. Louis MO 63166-6558

To FAX your prescription:
1. Both "Dr/Prescriber" and "Rx Form" boxes must be filled out.
2. Doctor can fax to: 1-866-272-8856
   - **Class II prescriptions cannot be faxed.**
   - Faxes will only be accepted from a doctor's office.

PATIENT

Member ID: _____

First Name: _____ Last Name: _____

Date of Birth: _____ Phone: _____

Address: _____

_____

_____

E-mail: _____

Allergies: _____

_____

Health Conditions: _____

_____

_____

Over-the-Counter Medications: _____

_____

DOCTOR/PRESCRIBER

DEA: _____

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

PATIENT OPTIONS

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

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

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Rx

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

First Name **Last Name**

Drug Name/Form/Strength	Qty	Directions for Use	Refills

X _____ **X** _____

Doctor/Prescriber Signature – Substitution Permissible

Doctor/Prescriber Signature – Dispense as Written

Stamped signatures cannot be accepted.

Health, Wellness & Anthem Advantages

Get the most out of your health plan

anthem.com/ca

Clear. Intuitive. Easy.

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

Health and wellness

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

MyHealth Assessment
Your first step toward a healthier lifestyle

Gain personal insights into your current health, your health risks, and what you can do to enjoy a healthier life. You complete a confidential assessment of your health and health care status, then receive a health assessment score and risk profile based on your specific answers. You also get tips and actions to help you improve your health.

To use MyHealth Assessment:

- Visit anthem.com/ca
- Click on "Health & Wellness"
- Under Health Assessment, select "Take my HA now"

SpecialOffers
Discounts on health-related products and services

Enjoy members-only discounts on vitamins, health and beauty products, chiropractic care, acupuncture, massage therapy, LASIK eye surgery, eyeglass frames and contact lenses, hearing aids, and audiology services, fitness center memberships, weight-loss programs and more.

To access all discounts:

- Log in at anthem.com/ca
- Click on "Health & Wellness"
- On far right side of page, see "Discounts"
- Click on "Access your Discount"

Plans and benefits

Anthem.com/ca makes complex information easy to understand and easy to use. That makes it easier to make the right decisions for you and your family.

Get the most out of your health plan

Anthem Care Comparison
Quality and cost information at your fingertips

Make informed decisions and save money by comparing actual costs for common procedures at hospitals and facilities in your area. In addition to price information, you can see procedure and quality comparisons that gauge performance and safety at each facility.

To use Anthem Care Comparison:

- Log in at anthem.com/ca
- Go to your Account Summary page and select "Compare Facility Cost and Quality"
- Click/drag/drop "Compare Cost & Quality"
- Select "Compare Facility Cost & Quality"

Coverage Advisor℠
A customized comparison of your health care needs and costs

You have a wide range of Anthem health plans to choose from; Coverage Advisor helps you choose the right one for you and your family. It helps you forecast your health care needs and costs and provides you with a clear comparison of benefit plans. If you have a medical savings account, it can also recommend contribution amounts to help cover expenses.

To use Coverage Advisor:

- Log in at anthem.com/ca
- Go to Resources under "Plans & Benefits"
- Select the Blue "Plans & Benefits" panel
- On the far right side, select "Access Coverage Advisors"

Claims look-up
Easy access to claims information

Stay on top of your medical claims with this easy online view. You can see the amounts charged to your medical savings account, the amounts paid by your traditional health coverage, or the amounts for which you're responsible. You may also choose to receive an email when a claim has been processed, instead of receiving notification by mail.

To look up a claim:

- Log in at anthem.com/ca
- Click on "Plans & Benefits"
- On right side Welcome area, select "Check Claim Status"

Online Provider Finder
The quick and easy way to find your doctor

Get the most out of your health plan

Search for doctors, hospitals and other health care facilities quickly online. You can make your search more specific by choosing a specialty or entering the name of a doctor or facility. If you're away from home, you can also search our National Directory.

To search our online Provider Finder:

- Visit anthem.com/ca
- Select "Find a Doctor" and simply follow the steps outlined on the screen

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

360° Health® programs

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

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

Take charge of your health and the choices you make

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

24/7 NurseLine

Round-the-clock access to health information can really help your peace of mind and your physical well-being. That's why we have Nurse Coaches ready to speak with you about your general health issues any time of the day or night. Just call the 24/7 NurseLine toll-free number to get answers to questions like these:

- Can the problem be treated at home?
- Do you need to see your doctor?
- Should you head straight to the emergency room?

Making the right call can help you avoid unnecessary worry and costs. And, most importantly, safeguard your health and the health of your family.

To reach 24/7 NurseLine, just call the customer service number on your ID card and ask to speak to a 24/7 NurseLine representative.

Future Moms

We know your goal is to have a safe delivery and a healthy baby. That's why we offer Future Moms, a voluntary program to help you take care of your baby before you deliver. Register for Future Moms and you'll get:

- 24/7 toll-free access to a registered nurse who'll answer your questions and talk to you about pregnancy-related issues.
- A helpful book: *Your Pregnancy Week by Week*
- Tips and facts to help you handle any unexpected events
- A questionnaire to see if you're at risk for preterm delivery

360° Health® programs

- Useful tools to help you, your doctor and your Future Moms nurse track your pregnancy and spot possible risks

Enroll in Future Moms by calling the customer service number on your ID card. Ask to speak to a Future Moms representative.

ConditionCare

If you or someone you love has an ongoing illness or health problem, let us help you get more out of life. Our ConditionCare nurses help people of all ages take care of the symptoms of asthma and diabetes. And they work closely with adults who have chronic obstructive pulmonary disease (COPD), heart failure and coronary artery disease. With ConditionCare you'll get the information you need to help you feel your very best. Our ConditionCare nurses gather information from you and your doctor. Then they create a personalized plan for you.

Information and support are as close as your phone. Call the customer service number on your ID card and ask to speak to a ConditionCare Nurse.

MyHealth Advantage

MyHealth Advantage can keep you and your bank account healthier.

Here's how it works: We review your health status daily and check to see what medications you're taking. If we see that any of your medicines could interact with each other, we tell your doctor right away. We also keep track of when you need to get routine tests and checkups. We send you a reminder called a "MyHealth Note" when you should make these appointments. MyHealth Note has a summary of all your recent claims. And from time to time, we give you tips on how to save you money on your medications.

ComplexCare

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

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

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

360° Health® programs

Staying Healthy Reminders

Sometimes we all need a reminder to be our healthy best. That's where Staying Healthy Reminders come in. We send you reminders about regular checkups and tests you should be having based on your age and sex. Staying Healthy Reminders cover just about everything from shots, mammograms and pelvic exams to testing for osteoporosis, colorectal cancer and cholesterol.

Keep an eye on your mailbox for your Staying Healthy Reminders.

Information You Should Know

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

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

Utilization Management

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

Medical reviews like this can be done before, during and after a member's treatment. Here's an explanation of each type of review:

The prospective or pre-service review (done before medical care is given)
A prospective review is done before a member goes to the hospital or has some other type of service or treatment.

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

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

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

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

Case Management

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

Your rights and responsibilities as an Anthem Blue Cross member

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

You have the right to:

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

You have the responsibility to:

- Choose any primary care physician (doctor), also called a PCP, who is in our network if your health care plan says that you to have a PCP.
- Treat all doctors, health care professionals and staff with courtesy and respect.

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

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

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

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Important legal information you should take time to read

Women's Health and Cancer Rights Act of 1998

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

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

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

HIPAA NOTICE OF PRIVACY PRACTICES

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

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

Your Protected Health Information

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

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

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

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

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

To You: We must give you access to your own PHI. We may also contact you to let you know about treatment options or other health-related benefits and services. When you or your dependents reach a certain age, we may tell you about other products or programs for which you may be eligible. This may include individual coverage. We may also send you reminders about routine medical checkups and tests.

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

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

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

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

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

Your Rights

Under federal law, you have the right to:

- Send us a written request to see or get a copy of certain PHI or ask that we correct your PHI that you believe is missing or incorrect. If someone else (such as your doctor) gave us the PHI, we will let you know so you can ask them to correct it.
- Send us a written request to ask us not to use your PHI for treatment, payment or health care operations activities. We are not required to agree to these requests.

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

- Give us a verbal or written request to ask us to send your PHI using other means that are reasonable. Also let us know if you want us to send your PHI to an address other than your home if sending it to your home could place you in danger.
- Send us a written request to ask us for a list of certain disclosures of your PHI.

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

How we protect information

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

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

Potential Impact of Other Applicable Laws

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

Complaints

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

Contact Information

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

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Important legal information you should take time to read

Copies and Changes

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

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

This Notice is provided by the following companies: **Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company**

STATE NOTICE OF PRIVACY PRACTICES

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

Your Personal Information

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

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

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

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

You have the right to access and correct your PI.

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

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

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

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Health care reform and your plan

You've probably heard a lot of people talk about health care reform lately. But you may have questions about what it all means for you and your family. Here's a quick review of what the law may mean to your group health plan. Keep in mind that other employers' plans may have different rules.

If you have questions about your specific benefits, call the customer service number on your member ID card or contact your group benefits administrator for a number to call.

JOIN IN.

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

What's changed: When you join, you'll have a chance to add young adult children to your plan.

The federal health care reform law lets children (also called dependents) stay on their parent's or guardian's health plan until the end of the month when they turn 26 years old. In some states, they can stay on the plan even longer.

Children can be on your plan even if they are not:

- Financially dependent on you for support
- Claimed as dependents on your tax return
- Residents of your household
- Enrolled as students or unmarried

If you have children younger than 26 who aren't on your plan now and your company offers coverage for children, you can add them to your plan during your next open enrollment. If your plan already covers children up to age 26, you don't have to do anything. They'll stay on your plan automatically.

What's changed: Children under 19 can get coverage even if they have health problems.

The law says group health plans can't deny coverage to children under 19 if they have pre-existing conditions (health problems). Here's how a website run by the federal government, called healthcare.gov, defines a pre-existing condition: a pre-existing condition is "a condition, disability or illness (either physical or mental) that you have before you enrolled in a health plan."

Very few group health plans deny coverage because of pre-existing conditions. But some plans still have waiting periods. A waiting period means that a child under 19 has to wait a certain amount of time before he or she can get covered for certain services.

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Health care reform and your plan (continued)

What's changed: No more lifetime maximum dollar limits.

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

What's new: You may have more choices in which doctors you can use.

This part of the law applies to you only if your plan says that you must choose a primary care physician (PCP) and get referrals from your PCP to see a specialist. If you have this type of plan (like an HMO):

- To serve you best, your medical group must be located within 15 miles or 30 minutes of your home or work. You can choose any PCP as your primary care doctor within the medical group you selected, as long as the PCP is accepting new patients and will accept you or your family members as patients.
- If your plan covers children, you may choose a pediatrician as their PCP.
- You don't need a referral from your PCP or prior approval from your health care plan to see a gynecologist or obstetrician, as long as those doctors are part of your medical group or the medical group has an arrangement with them and has identified them to provide care for its patients.

What's next? We'll keep you in the loop.

Things are going to keep changing for a while. This notice only includes changes that may affect you within the next year. We'll continue to keep you up to date to make sure you get all the benefits that can help you and your family get and stay as healthy as possible.

Anthem Blue Cross

Language Assistance Notice

Effective January 1, 2009

IMPORTANT: An interpreter can be provided for you to communicate with your doctor or health plan at no cost. To get an interpreter or to ask about written information in your language, please contact your group administrator.

IMPORTANTE: Se le puede brindar sin costo los servicios de un intérprete para que pueda comunicarse con su médico o plan de salud. Para obtener un intérprete o para solicitar información escrita en su idioma, comuníquese con el administrador de su grupo. (Spanish)

重要提示： 您與您的醫生或保健計畫交談時，可獲得免費口譯服務。如欲請翻譯員提供口譯，或欲查詢中文書面資料，請聯絡您的團體行政人員。(Cantonese or Mandarin)

중요: 의사 또는 건강보험사와의 의사소통을 위하여 통역사를 무료로 이용하실 수 있습니다. 통역이나 한국어로 번역된 정보를 원하시면 그룹 담당자에게 요청하시기 바랍니다. (Korean)

MAHALAGA: Mai-alok ang tagapagsalin sa iyo nang libre upang makipag-usap ka sa iyong doktor o planong pangkalusugan. Upang kumuha ng tagapagsalin o magtanong tungkol sa nakasulat na impurmasyon sa iyong lengguahe, paki-usap ang tagapangasiwa ng iyong pangkat. (Tagalog)

CHÚ Ý QUAN TRỌNG: Quý vị có thể được thông dịch viên giúp đỡ miễn phí khi quý vị cần tiếp xúc với bác sĩ hoặc nhân viên trong chương trình bảo hiểm sức khỏe của quý vị. Để được thông dịch viên giúp đỡ hoặc được cấp thông tin, văn bản chuyển ngữ sang ngôn ngữ của quý vị, xin quý vị vui lòng liên lạc ban quản trị chương trình bảo hiểm. (Vietnamese)

MCASH5459ML 12/08

Anthem Blue Cross Life and Health Insurance Company
Notice of Language Assistance

IMPORTANT: An interpreter can be provided for you to communicate with your doctor or health plan at no cost. To get an interpreter or ask about written information in your language, please call the phone number listed on the back of your ID card or contact your group administrator.

IMPORTANTE: Se le puede brindar sin costo los servicios de un intérprete para que pueda comunicarse con su médico o plan de salud. Para obtener un intérprete o para solicitar información en su idioma, llame al número que figura en el reverso de su tarjeta de identificación o póngase en contacto con el administrador de su grupo. (Spanish)

重要提示： 您與您的醫生或保健計畫交談時，可獲得免費口譯服務。如欲請翻譯員提供口譯，或欲查詢中文書面資料，請撥打您識別證背面的電話號碼，或聯絡您的團體行政人員。(Chinese)

CHÚ Ý QUAN TRỌNG: Quý vị có thể được thông dịch viên giúp đỡ miễn phí khi quý vị cần tiếp xúc với bác sĩ hoặc nhân viên trong chương trình bảo hiểm sức khỏe của quý vị. Để được thông dịch viên giúp đỡ hoặc được cấp thông tin, văn bản chuyển ngữ sang ngôn ngữ của quý vị, xin quý vị vui lòng gọi số điện thoại ghi phía sau thẻ hội viên của quý vị hoặc liên lạc ban quản trị chương trình bảo hiểm. (Vietnamese)

MAHALAGA: Mai-alok ang tagapagsalin sa iyo nang libre upang makipag-usap ka sa iyong doktor o planong pangkalusugan. Upang kumuha ng tagapagsalin o magtanong tungkol sa nakasulat na impurmasyon sa iyong lengguahe,paki-tawagan ang numero ng telepono na nakalista sa likod ng iyong ID card o paki-usap ang tagapangasiwa ng iyong pangkat. (Tagalog)

중요: 의사 또는 건강보험사와의 의사소통을 위하여 통역사를 무료로 이용하실 수 있습니다. 통역이나 한국어로 번역된 정보를 원하시면 가입자님의 ID 카드 뒷면에 있는 전화번호로 연락하시거나 그룹 담당자에게 요청하시기 바랍니다. (Korean)

ԿԱՐԵՎՈՐ. Ձեր բժշկի կամ առողջապահական ծրագրի հետ հաղորդակցվելու համար՝ Ձեզ անվճար թարգմանիչ կարող է մատակարարվել: Թարգմանիչ ստանալու կամ Ձեր լեզվով գրավոր տեղեկություններ մասին հարցնելու համար՝ խնդրվում է զանգահարել Ձեր ինքնության քարտի ետ§ի մասում գրված հեռախոսի համարով կամ կապվեք Ձեր խմբային կառավարչի հետ: (Armenian)

ПОМНИТЕ: Для общения с вашим врачом или представителем плана медицинского страхования вам могут предоставить бесплатные услуги переводчика. Для того, чтобы получить услуги переводчика или попросить о предоставлении информации в письменном виде на вашем языке, пожалуйста, позвоните по номеру, который указан на оборотной стороне вашей идентификационной карты (ID card), или свяжитесь с администратором вашей медицинской группы. (Russian)

重要事項： 医師、および、ヘルスプラン担当者との意思疎通には、通訳者による通訳サービスを無料で受けることが出来ます。通訳者サービス、または、あなたが話す言語で書かれた文書による情報を要請するには、あなたのIDカードの裏側に記載された電話番号に電話をするか、または、あなたの属するグループのアドバイザーに連絡をとってください。(Japanese)

توجه: مترجم شفاهی بصورت رایگان برای تسهیل ارتباط شما با پزشک و یا برنامه بهداشتیتان در درسترس می باشد. جهت درخواست مترجم شفاهی و یا اطلاعات کتبی به زبان مادری خود، لطفا با به شماره تلفن موجود در پشت کارت شناسائی (ID) زنگ بزنید و یا با مسئول گروهتان تماس بگیرید. (Persian)

ਜ਼ਰੂਰੀ ਸੂਚਨਾ: ਤੁਹਾਡੇ ਡਾਕਟਰ ਨਾਲ ਜਾਂ ਹੈਲਥ ਪਲਾਨ ਬਾਰੇ ਗੱਲਬਾਤ ਕਰਨ ਲਈ ਤੁਹਾਨੂੰ ਦੁਭਾਸ਼ੀਏ (ਅਨੁਵਾਦਕ) ਦੀ ਸੇਵਾ ਮੁਫਤ ਦਿੱਤੀ ਜਾ ਸਕਦੀ ਹੈ। ਦੁਭਾਸ਼ੀਆ ਲੈਣ ਲਈ ਜਾਂ ਲਿਖਤ ਜਾਣਕਾਰੀ ਪੰਜਾਬੀ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਕਿਰਪਾ ਕਰਕੇ ਆਪਣੇ ਆਈ.ਡੀ. ਕਾਰਡ ਦੇ ਪਿੱਛੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ ਜਾਂ ਆਪਣੇ ਗਰੁੱਪ ਪ੍ਰਬੰਧਕ ਨੂੰ ਸੰਪਰਕ ਕਰੋ। (Punjabi)

សារៈសំខាន់ ៖ យើងអាចផ្តល់អ្នកបកប្រែជូនអ្នកដោយឥតគិតថ្លៃ សំរាប់ក្រាស្រ័យទាក់ទងជាមួយនឹងគ្រូពេទ្យ ឬគំរោងសុខភាព របស់អ្នក ។ ដើម្បីទទួលអ្នកបកប្រែ ឬសាកសួរអំពីព័ត៌មានដែលសរសេរជាភាសាខ្មែរ សូមទូរស័ព្ទទៅលេខដែលមានកត់នៅលើ ខ្នងអត្តសញ្ញាណប័ណ្ណរបស់អ្នក ឬទាក់ទងអ្នកគ្រប់គ្រងក្រុមរបស់អ្នក ។ (Khmer)

TSEEM CEEB: Yeej nrhiav tau ib tug neeg pab txhais lus uas yuav pab koj nrog koj tus kws kho mob los sis pawg kho mob tham pub dawb rau koj. Yog xav tau ib tug neeg txhais lus los sis xav tau cov ntawv hauv koj yam lus, thov hu mus rau tus naj npawb xov tooj nram qab koj daim ID los sis hu mus rau tus neeg saib xyuas koj pawg hauj lwm. (Hmong)

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Description of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for the other health insurance or group health plan coverage (or if the employer stops contributing toward your or your dependents' other coverage); if a court has ordered coverage be provided for your dependents; if you meet or exceed a lifetime limit on all benefits under another health plan; or if you become eligible for assistance under a state Medicaid or SCHIP health plan with respect to cost of care under the employer's plan. However, you must request enrollment within 31 days after your or your dependents' other coverage is exceeded or ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage or domestic partnership, birth, adoption or placement for adoption or court order, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

To request special enrollment or obtain more information, please contact your employer's group health insurance representative.

If your health plan is subject to California state law, any special enrollment rights that apply to an eligible spouse also apply to an eligible domestic partner, as defined by your health plan.

Anthem Blue Cross

Completing Your Enrollment Form

At Anthem Blue Cross, we look forward to providing you with access to quality health care. We also make every effort to make enrollment in our health care plans as simple as possible.

Your employer has chosen an alternative enrollment process rather than using our standard enrollment form. Your Benefits Administrator or Human Resources Representative will be able to provide you with plan enrollment instructions.

At Anthem Blue Cross, we strive to make it easy to receive the kind of health care that's right for you.

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Anthem Blue Cross

Completar su formulario de inscripción

En Anthem Blue Cross, deseamos proporcionarle acceso a una asistencia médica de alta calidad. También hacemos un esfuerzo para que su inscripción en nuestros planes de salud sea lo más simple posible.

Su empleador ha elegido un proceso de inscripción alternativo en lugar de usar nuestro formulario de inscripción normal. Su Administrador de Beneficios o Representante de Recursos Humanos podrá proporcionarle instrucciones para la inscripción en el plan.

En Anthem Blue Cross, nos esforzamos para que le sea fácil recibir la clase de asistencia médica que es adecuada para usted.

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

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