Quick Reference Guide

PPO Plan

Important Information about your Anthem health plan

Anthem BlueCross BlueShield

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Introduction

This document provides a high-level look at the more commonly used parts of your Anthem health plan. It is not intended as a complete guide to your plan, nor is it a legal policy or contract. All benefits are subject to the provisions, limitations and exclusions in your contract. Your Anthem Blue Cross and Blue Shield policy is made up of your contract, any *endorsements*, the Schedule of Benefits, the Premium Explanation and your application. Please refer to these documents to determine the details concerning your benefits, coverage and obligations under your health plan. To obtain a copy of these documents contact your Customer Service Representative at the toll-free number on your identification card.

How to Obtain Medical Care and Information About Practitioners and Hospitals Who Participate in Your Health Plan

Your Primary Care Physician (PCP) is the physician you choose as your regular medical provider for most of your health care needs and decisions. A PCP is generally an internist, family practitioner, general practitioner or pediatrician. You are not required to get a referral from your PCP prior to going to a specialist, however, you may find that relying on your PCP to coordinate your care can result in lower out-of-pocket expenses.

Find a Doctor or Hospital
Each of our network PCPs meets our high standards for education, training and accessibility. To find a participating PCP, specialist or hospital, and information about the practice, visit our website at **anthem.com > Select a State > Enter > Find a Doctor**; or call your Customer Service Representative at the number on your ID card to request a printed provider directory.

Change Your Doctor
Our Individual plans do not require that you choose a PCP, therefore you can choose to go to any provider. Please see the Find a Doctor or Hospital paragraph above to locate a physician in the network.

How to Obtain Services from Providers Other Than Your PCP

Our Individual plans do not require that you choose a PCP, therefore you can choose to go to any provider.

Access to Specialist Services

The following chart outlines the related requirements associated with receiving medical care from our network of specialists and notes for each type of service whether benefits are available and what is required to properly access them to avoid unnecessary out-of pocket expenses.

Benefit	Anthem's Individual KeyCare PPO Plans (including Lumenos Plans)
PCP referral required to access in-network Medical Specialists services?	No
Allow for self-referral to network OB/GYN?	Yes
Allow for self-referral to outpatient in-network Mental Health or Substance Abuse Services?	Yes
Allow benefits for out-of-network provider services? (Available at higher cost to member)	Yes[1]
Does plan offer in-network walk-in or urgent care centers for urgent care services?	Yes
What is the time limit for filing a claim?	15 months from date of service

[1] Subject to out-of-network deductible, copayments and any cost-shares or penalties. Member is also responsible for any charges in excess of the maximum allowable amount.

Access to Hospital Services

Certain elective and emergency admissions, as well as certain surgical and non-surgical procedures, require advance approval to receive benefits. Hospital services, skilled nursing facility care, certain surgical procedures and certain advanced diagnostic imaging procedures typically require prior authorization.

Refer to your contract for more detailed information about the services that require admission review or prior authorization. However, in general:

- Whenever you are admitted to the hospital for a non-emergency admission, you, a friend, a family member, your provider or facility must contact us to receive admission approval for the proposed services. This call to us must be made in advance (prior to, or on the date of admission).
- Whenever you are admitted to the hospital in an emergency, you must contact us within 48 hours of your admission**.** If you are unable to do so, someone else may do it for you, but it is ultimately your responsibility.

Failure to receive prior authorization may result in penalties for medically necessary services or claim denials for claims that are determined not to be medically necessary.

To receive prior authorization you or your network provider can call the toll-free number on your identification card.

Access to Mental Health and Substance Abuse Services

Accessing services for mental health and substance abuse is easy, convenient and confidential. Please refer to the chart above for information on how to access these services.

How to Obtain Urgent Care Services

Urgent care is when you have a health care problem that needs immediate attention, but is not a life-threatening emergency. It's always best to call your doctor immediately to receive treatment. Your PCP, or a provider covering for your PCP, is on call 24 hours a day, including weekends. You should call him/her for urgent care needs, even after normal business hours. He/she can also help if you're away from home and need medical care. Otherwise, only self-referred benefits will be available, which means you may pay more out of your own pocket.

If you require urgent out-of-area care while traveling, coverage is available to Anthem members through the BlueCard Program. You can call your Customer Service Representative or call 1-800-810-BLUE (2583) to obtain names and locations of BlueCard participating providers. This is a national program that enables members of one Blue Cross and Blue Shield plan to obtain health care services while traveling in another Blue Cross and Blue Shield plan's service area.

If you need care while away from home for less than 90 consecutive days, follow these steps:

1. Always carry your current Anthem ID card.
2. In an emergency, go directly to the nearest hospital.
3. Call your primary care physician or Anthem for prior authorization and/or precertification. Anthem's number is located on your ID card.
4. To find nearby doctors and hospitals, call BlueCard Access at 800-810-BLUE (2583) or via the Web at www.bcbs.com > Blue Finder > Doctor Finder
5. When you arrive at the participating doctor's office or hospital, simply present your Anthem Blue Cross and Blue Shield ID card.
6. You should not have to complete any claim forms. The doctor will bill the local Blue Cross and Blue Shield plan.
7. You should not have to pay up front for medical services other than the usual out-of-pocket expenses (non-covered services, deductible, copayment and coinsurance).

NOTE: If you're unexpectedly admitted to the hospital, contact us within 48 hours of your admission. If you cannot call, someone else may do it for you, but ultimately it is your responsibility.

How to Obtain Services in an Emergency

Call 911 or immediately go to the nearest emergency room in an emergency situation.

If you have an emergency while outside the service area anywhere in the United States, follow the same steps described above. If the hospital participates with another Blue Cross and/or Blue Shield plan, your claim will be processed by the local plan. Be sure to show your Anthem identification card at the emergency room, and if you are admitted, notify your PCP or call the admission review number on the back of your ID card within 48 hours of admission. If the provider does not participate with a Blue Cross and/or Blue Shield program, you will need to file a claim.

In general:

- Use **emergency care** for something life threatening that requires immediate medical attention, or for an onset of symptoms that are so serious that you reasonably believe that emergency treatment is needed.
- Use **urgent care** when you have a health care problem that needs immediate attention, but is not a life-threatening emergency. It's always best to call your doctor immediately to receive treatment.

NOTE: If you're unexpectedly admitted to the hospital, contact us within 48 hours of your admission. If you cannot call, someone else may do it for you, but ultimately it is your responsibility.

Accessing Service Outside of Anthem's Provider Network or Service Area

For our PPO plans members have access to out-of-network providers. Out-of-network care is covered at a lower level of benefits than in-network care.

For needed medical care while traveling outside Anthem's service area, you may access care via our BlueCard® program. This is a national program that enables members of one Anthem Blue Cross and Blue Shield plan to obtain health care services while traveling in another Anthem Blue Cross and Blue Shield plan's service area.

Follow the steps outlined in the How to Obtain Urgent Care Services section above.

How to Submit a Claim

If you are using services provided by a doctor or provider in your health plan's network, you will not need to submit a claim. All paperwork is handled for you by the provider.

If you are a member of a plan that allows you to use out-of-network providers, you may need to submit a claim form.

Forms are available online at **www.anthem.com>Members>Select a State>Enter>Answers@Anthem>Download Forms>Individual Health Forms.** You can also order them by mail by calling the toll-free Customer Service number on your ID card. Mail your claim to the address indicated on the form.

Billing information to accompany the claim should include:

- name and address of the person or organization providing services or supplies;
- name of the patient receiving services or supplies;
- date services or supplies were provided;
- the charge for each type of service or supply;
- a description of the services or supplies received; and
- a description of the patient's condition (diagnosis).

Please reference the chart on page 4 for claim filing time limits.

Anthem's Pharmacy Benefits Program

Please note: Not all plans have pharmacy benefits. Check your Evidence of Coverage and your Summary of Benefits to see if you have this coverage.

Filling a Prescription Available Under Your Plan
To receive your pharmacy benefits, you must fill your prescription at a network pharmacy or through mail service pharmacy, if available under your plan. A list of network pharmacies can be found at **anthem.com** or by calling the Member Services number on your ID card. Check your Evidence of Coverage to determine if mail service pharmacy is included in your benefits.

You will have a copayment each time you fill a prescription, whether at a network pharmacy or through mail service pharmacy. Copayments may vary depending on whether the prescription is for a generic, preferred brand-name or non-preferred brand-name drug. Your copayment is listed on your Summary of Benefits.

Please note that some plans require that you purchase a generic drug when available and some plans do not cover brand name drugs at all. Using generic drugs, where appropriate, will help you maximize your benefits. Generic medications are required by law to meet the same manufacturing standards as their brand-name equivalents for safety, purity, strength and quality, but, in general, cost 30 to 60 percent less! See your Evidence of Coverage and your Summary of Benefits for details on your pharmacy benefits, limitations, exclusions, and copayments.

Prior Authorization

Special Prior Approval

We require prior review of selected drugs before payment is authorized. Contact our Member Services unit for a list of drugs requiring prior authorization. This list is periodically modified. A written request, including drug name, quantity per day and strength, period of time the drug is to be administered, medical condition for which the drug is being prescribed, the patient's name, identification number, date of birth, and relationship to the employee, must be sent by your doctor along with applicable medical records to:

Anthem Blue Cross and Blue Shield
Drug Prior Authorization MD-44E
P.O. Box 85040
Richmond, VA 23261-5040

You will be notified in writing when a prescription is denied for coverage. Your prescribing physician will be notified of both approval and denial decisions.

Network Pharmacy

For *prescription drugs* obtained at a retail pharmacy we cover up to a 30 day supply, or up to and including 100 units, whichever is less. For *prescription drugs* obtained through WellPoint's Mail Service Pharmacy, we cover up to a 90 day supply.

WellPoint's Mail Service Pharmacy

Please note: Not all members have mail service pharmacy as a benefit. Check your Evidence of Coverage and your Summary of Benefits to see if you have this coverage.

Express Scripts, Anthem's mail service pharmacy provider, is designed for customers who take prescription medications on a regular basis, for longer periods of time. This includes medications used to treat chronic conditions such as high cholesterol, diabetes, high blood pressure, arthritis or depression, as well as medications used on a regular basis such as oral contraceptives.

Save money
How much you save depends on the medication you are taking and your prescription drug plan. Because your doctor is permitted to write prescriptions for the maximum days supply allowed by your health plan, which is normally three months, Express Scripts typically can dispense the larger days supply with fewer copayments or coinsurance (see your schedule or Summary of Benefits).

Free shipping, timely delivery
Your prescriptions will be shipped promptly and securely seven days from receipt of your valid order. Make sure you have enough medication on hand until your mail service prescription can be delivered. Ask your physician to write a prescription for a one-month supply to be filled at a local pharmacy.

Ordering Your Prescription by Mail

New prescriptions
Ordering with an original written prescription
If you have a written prescription from your physician for the maximum days supply allowed by your health plan, mail the prescription, along with an order form and payment to:

Express Scripts
P.O. Box 66785
St. Louis, MO 63166-6785

Order forms can be downloaded from anthem.com. Click on Customer Care (located on the top right hand corner), select Virginia, and then click on Download Forms.

If you do not have an original written prescription on hand:

Express Scripts can contact your physician. Call 800-782-8473 and a Member Service associate will contact your physician for a new prescription. You must provide your prescription information, physician's name, phone number, names and strengths of medications, and credit card information for payment.

Have your physician fax your prescription information. The prescription must be faxed directly from the office of the prescribing physician to 800-600-8105. If at any time there is a question about your prescription, Express Scripts will contact your physician.

Ordering refills
You can order refills of your Express Scripts prescription one of three ways:

1. Internet: www.anthemprescription.com; click on Members and follow the instructions to log in or register (first-time users only).
2. Mail: Use the convenient preprinted refill order form included with every order and mail, along with payment, to: Express Scripts Home Delivery Pharmacy; P.O. Box 66785; St. Louis, MO 63166-6785.
3. Phone: 866-281-4279. Please have your prescription and payment information readily available.

For more information
If you have questions regarding our mail pharmacy, contact Member Services at 866-281-4279, Monday-Friday, 8 a.m.-11 p.m. or Saturday 8 a.m.-7 p.m. (EST). For speech and hearing impaired assistance (TTY/TDD), call 800-221-6915.

Procedures for Filing a Complaint or Appeal with Anthem

Complaints include any expression of dissatisfaction regarding Anthem's services, products, network provider or employees that do not involve a plan decision.

Appeals typically involve a request to reverse a previous decision made by us.

Complaint Process

Upon receipt, your complaint will be reviewed and investigated. You will receive a response within 30 calendar days of our receipt of your complaint. If we are unable to resolve your complaint in 30 calendar days, you will be notified on or before calendar day 30 that more time is required to resolve your complaint. We will then respond to you within an additional 30 calendar days.

IMPORTANT: Written complaints or any questions concerning your health insurance may be filed to the following address:

Anthem Blue Cross and Blue Shield

P.O. Box 27401

Richmond, Virginia 23279-7401

Complaints against a plan network provider

If you have a concern about the quality of care or service rendered by a specific provider, we want to know about it. Typically you can submit your concerns to us in writing or by calling Customer Service at the number on the back of your ID card. Our Quality Management team will fully investigate the matter. Appropriate action will be taken with the provider. Due to confidentiality requirements, specific actions taken by us and/or the provider may not be able to be specifically reported back to you.

How to appeal a coverage decision

To appeal a coverage decision, please send a written explanation of why you feel the coverage decision was incorrect. Alternatively, this information may be provided to a Customer Service Representative over the phone. This is your opportunity to provide any new information that you feel we should consider when reviewing your appeal. Please include with the explanation:

- the patient's name, address and telephone number;
- your identification and group number (as shown on your identification card); and
- the name of the health care professional or *facility* that provided the service, including the date and description of the service provided and the charge.

IMPORTANT: You may contact us with your appeal or any questions concerning your health insurance at the following:

Anthem Blue Cross and Blue Shield
Attention: Corporate Appeals Department
P.O. Box 27401
Richmond, VA 23279-7401

Telephone:
540-342-7352 in Roanoke
800-553-3164 from outside Roanoke

You must file your appeal within either 15 months of the date of service or 180 days of the date you were notified of the adverse benefit determination, whichever is later.

Virginia Bureau of Insurance

If you have been unable to contact or obtain satisfaction from Anthem, you may contact the Virginia Bureau of Insurance, 1300 East Main Street, P. O. Box 1157, Richmond, VA 23218,
in Richmond (804) 371-9741, from outside Richmond (800) 552-7945.

The Office of the Managed Care Ombudsman

If you have any questions regarding an appeal or grievance concerning the health care services that you have been provided which have not been satisfactorily addressed by your health plan, you may contact the Office of the Managed Care Ombudsman for assistance at any of the following:

The Office of the Managed Care Ombudsman
Bureau of Insurance
P.O.Box 1157
Richmond, VA 23218

Telephone:
804-371-9032 in Richmond
877-310-6560 from outside Richmond
(Note: This number is separate from the Bureau's existing toll-free number and is exclusive to The Office of the Managed Care Ombudsman)

E-Mail: ombudsman@scc.virginia.gov
Web Page: Information regarding The Office of the Managed Care Ombudsman may be found by accessing the State Corporation Commission's web page at: http://www.scc.virginia.gov

The Virginia Department of Health Office of Licensure and Certification

If you have any questions regarding a complaint and/or an appeal concerning the health care services that you have been provided which have not been satisfactorily addressed by us, you may contact the Virginia Department of Health Office of Licensure and Certification for assistance at any of the following:

Office of Licensure and Certification
Virginia Department of Health
9960 Mayland Drive, Suite 401
Richmond, VA 23233

Telephone:
Complaint Hotline: 800-955-1819
Richmond Metropolitan Area: 804-367-2106
Fax: 804-527-4502
E-Mail: MCHIP@vdh.virginia.gov

Independent external review of adverse utilization review decisions

You or a provider that has your consent may appeal to the Virginia Bureau of Insurance for review of any final decision concerning a health service that costs you $300 or more. This right of appeal is only available in cases when final decisions were based on medical necessity or experimental/investigative guidelines, including any such decision made as the result of an expedited appeal and any denial of a

request to render such a decision on an expedited basis. The Virginia Bureau of Insurance may require a non-refundable fee.

Laws governing these health plans

These health plans are entered into in, and are subject to the laws of, the Commonwealth of Virginia. Your coverage is a Managed Care Health Insurance Program subject to regulation in the Commonwealth of Virginia by both the Virginia State Corporation Commission's Bureau of Insurance pursuant to Title 38.2 and the Virginia Department of Health pursuant to Title 32.1.

How Anthem Evaluates New Technology for Inclusion as a Covered Benefit

Nearly every day, the media reports stories on new devices, medications and medical procedures. That's not surprising when you consider that the medical, behavioral and pharmaceutical health fields constantly change. Anthem stays informed about medical advances and, when appropriate, creates or updates certain policies to address these new technologies. In addition, our medical, behavioral and pharmaceutical policies – which specify services covered and under what circumstances – are evaluated and reviewed periodically by teams of health care professionals who base their opinions on recent medical literature and scientific data. Examples of materials that may be reviewed when making medical, behavioral and pharmaceutical policy decisions on new medications, devices and procedures are:

- Peer-reviewed, professional medical publications and journals
- The policies/procedures of government agencies (the Food and Drug Administration and the National Cancer Institute)
- Credible results indicating the positive impact the medical technology has on long-term health
- The opinions of physicians, specialists and other health care consultants

Anthem's 24/7 NurseLine Available to Lumenos Plans Only

Anthem's 24/7 NurseLine is available at no extra cost 24 hours a day, seven days a week. With our 24/7 NurseLine, you get around-the-clock access to nurses in times of urgent need or when you just have a general question that comes up at any time, day or night. Registered nurses are available to help you assess symptoms, locate providers or provide information on diagnoses, medication or other medical issues. You also have access to an AudioHealth Library where you can access recorded information on more than 300 topics in both English and Spanish simply by calling our 24/7 NurseLine telephone number located on your ID card..

Anthem's Quality Program

Summaries of our quality program, outlining our quality and service initiatives and results, are available on our website at anthem.com>Member>Select State>Enter>Communications>General Information>The Rising Costs of Healthcare.

Or, if you would like to request a copy of the quality program, please send your request to Quality Improvement Consultant, 2221 Edward Holland Drive, Mail Drop VA4002-G000, Richmond, VA 23230.

Member Rights and Responsibilities

With your Anthem health plan you have certain rights and responsibilities which are outlined below:

Making the Most of Your Coverage. Successful partnerships take a strong commitment from all sides – each recognizing the rights and responsibilities of the other. Your health care is no different. It takes a strong partnership

between you, your health care professionals and Anthem Blue Cross and Blue Shield for coverage you can count on. Following is a statement of rights and responsibilities for our partnership with you.

You have the right to receive prompt treatment and service. When it comes to your health care, you should always be treated promptly, with courtesy and respect and receive the medical services you need from health care professionals. Likewise, when you have questions or need help with the benefits of this policy, you should always receive prompt and courteous service from Anthem Blue Cross and Blue Shield employees.

You have the right to know about all your treatment options and to participate in all discussions and decisions about your care . We encourage the health care professionals in our networks to discuss with you all treatment options regardless of cost or whether your benefits will cover the care. We encourage you to discuss each of these treatment options with your doctor and to participate in the decision about your course of care.

You have the right to choose any doctor you want, and receive any treatment that they will provide. Perhaps the single most important part of the health care system is your flexibility to see any doctor or receive any treatment that you want. You will get the most from your benefits when you use Anthem participating providers for covered services, but you are not prevented from visiting the doctor you want to see or from receiving the care you and your doctor feel you need. Keep in mind, however, that if the care you receive is not covered by your policy, we will not be able to cover the service. This policy has rules that describe what services can and cannot be covered, and what types of health care professionals can and cannot receive payments from Anthem. Because your policy is a contract, we are legally obligated to follow these rules. But regardless of whether your benefits apply to a particular service, the choice of what care to receive is always yours.

You have the right to privacy. Whether by health care professionals or Anthem Blue Cross and Blue Shield employees, you should always be treated with dignity, and your right to privacy should always be respected. We abide by the Commonwealth of Virginia Privacy Protection Act and have a number of other procedures in place to ensure your privacy. Any medical information about you that we receive, including your medical records from health care professionals or hospitals, will be kept confidential and, except as permitted by law, will not be made available to anyone without your written permission. You can review any personal information collected about you by Anthem Blue Cross and Blue Shield, and corrections can be made at your request.

You have the right to seek other health care coverage if you lose or leave your coverage. Your individual health care coverage with Anthem cannot be cancelled as long as:

- premiums are paid in accordance with the terms of the policy;
- you continue to live, work, or reside in our service area; and
- there are no fraudulent or material misrepresentations on your application or under the terms of your coverage.

However, we can refuse to renew this coverage if all policies of the same form number are also not renewed. This would be done in accordance with applicable laws.

If you move out of Anthem's service area, you have other options. Depending on factors such as your eligibility for other plans, your age and your state residency, you may be eligible for either another Blue Cross Blue Shield plan, a plan offered by another carrier or a government-sponsored program. An Anthem service representative can guide you to other Blue Cross Blue Shield plans that may be available to you.

You have the right to voice complaints or file appeals. Our Customer Service Representatives can resolve most of your concerns if you are ever dissatisfied with Anthem Blue Cross and Blue Shield or the care you received from an Anthem participating health care professional. But, if you remain dissatisfied, you may file a complaint or appeal a decision, as explained in this policy.

You have the right to information. While you are enrolled as an Anthem Blue Cross and Blue Shield covered person, we will periodically send you information on how to use the benefits and features of your policy. You may also request certain information about Anthem, its services, your rights and responsibilities and the health care professionals who contribute to your care by contacting Anthem's Customer Service department.

You have the right to designate an authorized representative. You have the right to designate an authorized representative to act on your or the patient's behalf in pursuing a claim or an appeal of an adverse benefit determination. This authorization may be granted for a particular event or date of service after which time the authorization approval is revoked, or may be granted for any present or future claim for health care benefits you may have. Designations of authorized representative status are most appropriate when being granted to a health care provider or an attorney that may be representing you in connection with a claim. Designations of authorized representative status for any present or future claims for health care benefits are more appropriately made to family members and other trusted persons whom you may wish to authorize to assist you in the future with health care claims matters. Explanation of Benefits statements will not be directed to your authorized representative, but will continue to be sent to you or the patient. To initiate the designation process, contact Anthem's Customer Service department.

You have the right to make recommendations regarding the rights and responsibilities set forth here. Being a partner in your health care means remaining involved in and informed about the decisions that affect your health. At Anthem Blue Cross and Blue Shield we welcome all suggestions regarding what your rights and responsibilities as a member should be, as well as what our rights and responsibilities as your health plan should be. If you should have any questions, comments, or suggestions, please contact Anthem's Customer Service Department.

RESPONSIBILITIES

You have the responsibility to work together with providers and their staff . Be a partner with your health care professionals and their treatment staff by following their advice and the care they recommend. Take the necessary steps to have your previous medical records, and any updates, transferred to your current doctor. And to the extent possible, provide your doctors with the information about your health and health habits that they may need in order to appropriately care for you. You have the responsibility of understanding your health problems and participating in developing mutually agreed upon treatment goals. If you have questions or disagree with the treatment plan, discuss it with your provider. Make sure you understand the medications you are taking and whether you are scheduled for follow-up visits.

You have the responsibility to keep all diagnostic or treatment appointments as scheduled. Please consider the needs of others by being on time for appointments you schedule with health care professionals. And because giving patients the full attention they need does not always allow providers to stay on schedule, please be understanding if you have to wait before your provider can see you.

You have the responsibility to make your payment to the provider at the time of your visit. Please be prepared to make your applicable payments (such as a copayment and/or deductible for participating/in-network providers and a copayment, deductible and/or coinsurance for non-participating/non-network providers) when you receive your services.

You have the responsibility to notify Anthem of any changes that may affect your membership records. When a change occurs in your residence, number of dependents or in coverage available through another health insurance plan (adding secondary coverage or discontinuing it, for example), it is important to notify us because the change may affect your coverage.

You have the responsibility to take an active role in managing your health. Good health management means following the advice and instructions of your doctor and making the lifestyle changes your doctor recommends.

You have the responsibility to know what is considered emergency care and what is considered urgent care. Be familiar with when to use the emergency room for care (immediately for any life-threatening condition, no matter where you are) and when to seek care from your family doctor (non-life-threatening illnesses or injuries – urgent care). "Emergency services," "emergency care," or "medical emergency" means those health care services that are provided for a condition of recent onset and sufficient severity, including but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to obtain immediate medical care could result in:

(a) Placing the patient's health in serious jeopardy;
(b) Serious impairment to bodily functions; or

(c) Serious dysfunction of any bodily organ or part.

Examples of these conditions include but are not limited to, chest pain, stroke, poisoning, serious breathing difficulty, unconsciousness, severe burns or cuts, uncontrolled bleeding, or convulsions.

In an emergency, go to the nearest appropriate doctor or hospital, or call 911 for assistance. If you need non-emergency medical care after regular visiting office hours, call your physician's office.

Anthem's Utilization Management Program

Utilization management is a review process that helps manage health care resources and maximize the effectiveness of care. This process helps determine the most appropriate settings and resources for treating a particular medical condition.

- Utilization management decisions are based solely on the appropriateness of care and services.
- Individuals who make utilization review decisions do not receive compensation or incentives to deny care; nor do the individuals who supervise them, including upper management, medical directors, utilization review managers and licensed utilization management staff.
- The plan does not specifically reward for denial of services, nor do we offer incentives to encourage denial of services.

Independent Review of Anthem's Utilization Management Decisions

As a health plan member, you have the right to voice complaints or file appeals about your health plan or the care you are provided. This includes the right to request an independent external review through your state's insurance department. Before requesting an external review, you must normally exhaust the internal appeal process. Please note that the external review process is only available for members of fully insured health plans.

Anthem's Privacy Practices

HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how health, vision and dental information about you may be used and disclosed, and how you can get access to this information with regard to your health benefits. Please review it carefully.

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

Your Protected Health Information

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

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

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

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

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

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 with coroners, funeral directors or medical examiners (about decedents). PHI can also be shared with organ donation groups for certain reasons, 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 him or her to correct it.
- Send us a written request to ask us not to use your PHI for treatment, payment or health care operations activities. We are not required to agree to these requests.
- Give us a verbal or written request to ask us to send your PHI using other means that are reasonable. Also, let us know if you want us to send your PHI to an address other than your home if sending it to your home could place you in danger.
- Send us a written request to ask us for a list of certain disclosures of your PHI.

Call Customer Service at the phone number printed on your identification (ID) card to use any of these rights. Customer Service representatives 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, and have 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 securing offices that hold PHI, password protecting computers, and locking storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. These 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 nonaffiliates 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. Representatives can help you apply your rights, file a
complaint or talk with you about privacy issues.

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

Breast reconstruction surgery benefits
If you ever need a benefit-covered mastectomy, we hope it will give you some peace of mind to know that your Anthem 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. Contact your Plan administrator for more information.

STATE NOTICE OF PRIVACY PRACTICES

As mentioned in our Health Insurance Portability and Accountability Act (HIPAA) notice, we must follow state laws that are stricter than the federal HIPAA privacy law. This notice explains your rights and our legal duties under state law. This applies to life insurance benefits, in addition to health, dental and vision benefits that you may have.

Your Personal Information

We may collect, use and share your nonpublic personal information (PI) as described in this notice. PI identifies a person and is often gathered in an insurance matter. 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 español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

This Notice is provided by:
Anthem Blue Cross and Blue Shield

Benefits, Services and Member Cost Sharing Information

Information regarding the services covered under your Anthem health plan is available to you by clicking on this link:.[Add link to Summary of Benefits page] This will bring you to a list of covered services as well as the limitations and your cost sharing responsibilities for each service type. This information is tailored to your specific plan. If you require additional information or copies of your health plan Contract, Schedule of Benefits, etc., call Customer Service at the toll-free number on your Anthem identification card.