Anthem BlueCross

Individual and Family Health Care Plans
for California

Our plans fit your plans

Lumenos® HSA Plus

CABR10006XLS Rev. 10/12

Our plans fit the way you live.

In a world that's constantly changing, one thing's for certain: it's important to have health care coverage you can depend on – coverage designed to help fit your budget, and your way of life.

Since 1937, Anthem has provided health care coverage and security to our California neighbors. And our Individual health care plans now include added benefits and features of the Affordable Care Act. You can rest assured knowing you'll be covered by a company that has the experience, financial stability and provider network to meet your needs and the industry changes that lie ahead.

You're in charge of your health and budget, and our Individual health care plans help keep it that way. We still offer a wide range of coverage options as unique as you are. And if you have any questions, we're here to help.

Why do you need health care coverage?

These days, an average stay in the hospital can cost more than $30,000.* The financial risk you take without health coverage just isn't worth it. Not only does health coverage help you stay healthy, it also gives you added security, because you know you're protected against the high cost of unexpected medical bills.

Experience you can rely on

Anthem Blue Cross is committed to helping simplify your life and improving your health. That's why we offer:

- **Optional dental and term life insurance.** To enhance your health and your family's financial future, we also offer dental and term life coverage and make it easy to enroll.
- **Coverage that travels with you.** No matter where life takes you, your health coverage goes with you. And the BlueCard® program makes it easy to access providers throughout the country.
- **Choose your doctor and compare your health care costs at anthem.com.** Manage your health care coverage in a simple and easy way at anthem.com. Once you're a member, all you have to do is register at anthem.com and start feeling better about your choices with features like:
  - *Find a Doctor:* Use our online Provider Directory to find hospitals, pharmacies and other specialists in your area — and check whether they are cost-saving network providers — all at the click of a mouse.
  - *Estimate Your Cost:* Save time and money by comparing the quality and safety of providers as well as the cost of common procedures at health care facilities in your area.
  - *Zagat Health Surveys:* See what other patients have said about the doctors and hospitals you're considering. Add your own doctor recommendation, too!

Register at anthem.com and have a wealth of health information right at your fingertips.

* Based on 2009 weighted national estimates from HCUP National Inpatient Sample (NIS), Agency for Healthcare Research and Quality (AHRQ), based on data collected by Individual states and provided to AHRQ by the states. (Average stay of 4.6 days; average cost to uninsured of $30,655.)

Some definitions so we're all on the same page

Network Discounts: With Anthem, you have access to one of the largest provider networks in the state. These network (or participating) providers have agreed to accept lower costs for their covered services to Anthem members — similar to volume discounts. These negotiated costs help reduce the overall cost of covered medical services, including your share of those costs.

This is true whether you are paying the entire cost for covered services (such as while you are meeting your deductible), or whether we are sharing the cost. With over 82,000 doctors and more than 370 hospitals, chances are your provider already participates. Just visit a network provider to take advantage of the savings.

With our PPO plans, you can always choose to receive services outside the network, but your share of the cost will be greater.

Cost–Sharing: The costs of medical care today can be staggering. Health care coverage from Anthem can help protect you against these high costs. With most health care coverage, you pay a monthly premium, then you share some of the cost of covered medical care with the company that provides your health care coverage. The level of cost-sharing you choose directly impacts your premium amount. The more you are willing to share in the cost, the lower your premium. With Anthem, you can choose your level of protection and the level of cost-sharing that works best for your health care needs and budget.

Deductible is the amount you have to pay each calendar year for covered services before your health care plan starts paying. For some services, the plan will even begin to pay before the deductible is met. Usually, the higher a plan's deductible, the lower the premium. In some cases, you may also have a separate deductible for certain services such as prescription drugs.

Coinsurance is the percentage of the cost of covered services that you will be responsible for, after your annual deductible is met. With some plans, you have a choice of coinsurance levels. For some services, your coinsurance is 0%. Much like your deductible, selecting a higher coinsurance typically lowers your monthly premium because it increases your share of the cost.

Copayment is a specific dollar amount you have to pay for certain covered services.

Out-Of-Pocket Maximum is the most that you would pay in a calendar year for deductible and coinsurance for in-network covered services. Once you reach this maximum, the plan pays at 100% for most services for the rest of the calendar year.

Prescription Drugs are medications that must be authorized for use by your doctor. Anthem offers varying levels of prescription drug coverage. Depending on the plan, you may have coverage for generic drugs or generic and brand name drugs.

Generic Drugs are prescription drugs that typically have been in use for some time and can be manufactured and distributed by numerous companies, so their cost is usually much lower. Generic drugs must, by law, contain the same active ingredients as their brand name equivalent and have the same clinical benefit.

Brand Name Drugs are prescription drugs that are manufactured and marketed under a registered name. They are usually patented and may be exclusively offered by certain manufacturers.

Specialty Drugs are typically high cost, scientifically engineered drugs used to treat complex, chronic conditions. They require special handling and usually must be shipped directly to the user.

Formulary is a list of prescription drugs our health care plans cover. They include generic, brand name, and specialty drugs that have been rigorously reviewed and selected by a committee of practicing doctors and clinical pharmacists for their quality and effectiveness. We've negotiated lower prices on these formulary drugs, so you'll save when your doctor prescribes medication from our formularies. There can be different formularies for different health care plans.

Health Savings Account (HSA) is a special bank account that can be set up by a member enrolled in a qualified HSA-compatible high-deductible health plan if they choose. Contributions to this account can be made with certain tax advantages and funds from the account can be used for qualified health care expenses. See the insert from our preferred banking partner for more details and consult your tax advisor.

Lumenos® HSA Plus

Is this the right plan for you?

Lumenos HSA Plus health plans were designed to give you more control over your health care costs. They help you focus on getting healthy and staying that way.

Prescription Drug Coverage

Lumenos HSA Plus not only puts you in charge of your health care dollars, it can help you use those dollars for generic and brand name prescription drugs in the way that best suits you.

Once your deductible is met, covered prescription drugs are covered at 100%. And even while you are meeting your deductible, you benefit from lower negotiated rates on prescription drugs at network pharmacies nationwide. There's no need to have a different deductible or copayment for prescriptions; it all works as one.

And since you decide how to spend it, your Health Savings Account dollars can be used to pay for prescription drugs while you are meeting your deductible.

How to Customize your Lumenos HSA Plus Plan

Choose your deductible: You can usually lower your premium by choosing a higher deductible. Simply choose the deductible and premium combination that works best for you. Remember, any covered member can contribute to some or all of the policy deductible and out-of-pocket maximum, whether the policy covers one member or a whole houseful.

Use your Health Savings Account the way you want: Your HSA, if you choose to open one, is funded by you. So, it is yours to use for qualified health care expenses covered by the plan, or those not covered at all, like contact lenses. Your HSA is also yours to keep if you ever leave the plan; you won't lose those dollars if they're not used. In fact, the carryover from year to year can help you save for future financial needs. See the enclosed insert from our preferred banking partner for more information.

Other Optional Coverage: You can add more protection for you and your family by purchasing optional dental or life insurance. See the following pages for details.

Lumenos HSA Plus Plan Highlights

This plan offers traditional health coverage benefits that can be paired with a Health Savings Account (HSA) for more flexibility and potential tax advantages. Simple plan designs make using them that much easier.

Features:

- Preventive care benefits help focus on keeping you healthy.
- PPO health plan coverage with a large array of benefits after you pay your deductible.
- Network services covered 100% after you meet your deductible.
- Coverage compatible with an HSA that is yours to fund and keep if you choose. Use the HSA for qualified medical expenses or as a savings vehicle. Just contact your tax advisor for possible advantages.
- Special programs for Smoking Cessation and Weight Management.
- Access to our 24-hour Nurse Line.

Online tools for a personalized Health Assessment, prescription drug cost comparison, and other tools to give you more control.

You should know:

- Your Lumenos HSA Plus plan has a policy-level deductible and out-of-pocket maximum. Once any combination of covered members on the policy meet these amounts, the plan pays 100% of covered expenses. It's that simple.
- While Lumenos HSA Plus is compatible with a Health Savings Account, your health care plan works with or without it. You may set up the HSA now, later, or not at all. It's your choice.

Benefits		Lumenos® HSA Plus			
Calander year deductible		Your choices			
		Single policy coverage:	Family policy coverage:	Family policy coverage:	
Individual	Network:	$5,950	N/A	N/A	
	Non-network:	$5,950			
Family	Network:	N/A	$5,500	$7,500	$11,900
	Non-network:		$5,500	$7,500	$11,900
Network coinsurance options		0%	0%	0%	0%
Calendar-year Out-of-pocket Maximum		Add Your Chosen Deductible to the Amount Below			
		Single policy coverage:	Family policy coverage:	Family policy coverage:	
Individual	Network:	$0	N/A	N/A	
	Non-network:	$5,950			
Family	Network:	N/A	$0	$0	$0
	Non-network:		$5,500	$7,500	$11,900
How family deductibles and family out-of-pocket maximums work		Not applicable for Single policy coverage	Either one or more members must meet the family deductible. The family out-of-pocket maximum can be met by either one or more members. Once the maximum is met, no additional coinsurance will be required for the family for remainder of the calendar year.	Once one family member reaches half of the family deductible or out-of-pocket maximum, the remaining amount of the family deductible or out-of-pocket maximum needs to be met by one or more other family members. The family deductible or out-of-pocket maximum can be met by the family combined. Once the maximum is met, no additional coinsurance will be required for the family for remainder of the calendar year.	
Plan lifetime maximum		None			

Covered Services	Your Share of Costs (after deductible, unless waived)
Doctor office visits	Network: 0% Coinsurance Non-network: 40% Coinsurance
Professional and diagnostic services (X-ray, lab, anesthesia, surgeon, etc.)	Network: 0% Coinsurance Non-network: 40% Coinsurance
Inpatient services (overnight hospital/facility stays)	Network: 0% Coinsurance Non-network: 40% Coinsurance
Outpatient services (without overnight hospital/facility stays)	Network: 0% Coinsurance Non-network: 40% Coinsurance
Emergency room services	Network: 0% Coinsurance Non-network: 0% Coinsurance
Preventive care services	Covers all nationally recommended preventive care services, including well-child care, immunizations, PSA screenings, Pap tests, mammograms, and more. Network: 0% Coinsurance, not subject to deductible Non-network: 40% Coinsurance
Maternity	Maternity services are covered as other services outlined above in the covered services section of this benefit guide.
Optional coverage (at additional cost)	Dental, Life

Prescription Drug Coverage	Lumenos HSA Plus
Retail drugs (and mail-order drugs, when available)	Network: 0% Coinsurance Non-network: 40% Coinsurance
Optional drug coverage (when available)	Not Available
Other covered benefits include, but are not limited to:	Acupuncture, Ambulance, Chiropractic Services, Home Health Care, Mental Health, Physical/Occupational Therapy, Urgent Care (Visit limitations may apply for some of these benefits.)

IMPORTANT: This Benefit Guide is intended to be a brief outline of coverage and is not intended to be a legal contract. The entire provisions of benefits, limitations and exclusions are contained in the Contract/Certificate of Coverage. In the event of a conflict between the Contract/Certificate of Coverage and this Benefit Guide, the terms of the Contract/Certificate of Coverage will prevail.

NOTES:

- Network and non-network deductibles are separate and do not accumulate toward each other. Network and non-network out-of-pocket maximums are also separate and do not accumulate together.
- Lumenos HSA plans feature a combined medical/pharmacy deductible so your payments for prescription drugs also apply toward your plan deductible and out of pocket maximum.

Affordable Dental Blue® PPO solutions designed to meet your dental needs

Dental Blue Basic offers:

- Low plan premiums
- Coverage for many diagnostic services and preventive care such as cleanings, exams and X-rays with no waiting period
- Coverage for certain basic services (fillings) with a six-month waiting period
- An annual maximum benefit of $500

Dental Blue Enhanced offers:

- Coverage for many diagnostic services and preventive care such as cleanings, exams and X-rays with no waiting period
- Coverage for certain basic services (fillings) with a six-month waiting period
- Coverage for certain major services like root canals, periodontal procedures and crowns after a 12-month waiting period
- An annual maximum benefit of $1,250
- Orthodontic coverage for children after a 12-month waiting period

Save money by using our dental network

As a Dental Blue member, you can see any dentist you want; however, you do have the potential for lower costs when you choose a dentist in the Dental Blue 100 network. This is because network dentists have agreed to accept our negotiated rates for services they provide to you. If you choose to go to a provider outside of the Dental Blue 100 network, you can be billed the difference between our network negotiated rates and what your chosen dentist wishes to charge. But, with more than 20,000 California providers and provider locations in our Dental Blue 100 network, it's likely your dentist is part of our network!

Plus, network dentists have agreed to pass along our negotiated rates on covered services to you during waiting periods, if you exceed your annual maximum benefit, or if you exceed frequency limitations allowed for a covered service. For example, both Dental Blue Basic and Dental Blue Enhanced provide coverage for two cleanings per year. Members who get a third cleaning would receive our negotiated rates for that service.

You will also have access to emergency dental care from our worldwide listing of credentialed dentists while traveling or working nearly anywhere in the world.

Prefer a Dental HMO?

If so, our Dental SelectHMO plan may be the right choice for you. For more information about the Dental SelectHMO plan — or our Dental Blue plans — ask your agent.

Amounts shown below are paid by the plan, after the deductible.

Dental Care Coverage	*Dental Blue Basic*		*Dental Blue Enhanced*	
Benefits	**Network**	**Non-Network**	**Network**	**Non-Network**
Annual Deductible	$25 per member		$50 per member; $150 maximum per family	
Waived for Diagnostic & Preventive	Yes	No	Yes	No
Annual Maximum	$500		$1,250	
Diagnostic and Preventive	**Network**	**Non-Network**	**Network**	**Non-Network**
Cleanings, exams and X-rays	100%	80%	100%	80%
Basic Services	**Network**	**Non-Network**	**Network**	**Non-Network**
Fillings	80%	60%	80%	60%
Other Minor Restorative	Not covered			
Major Services	**Network**	**Non-Network**	**Network**	**Non-Network**
Oral Surgery	Not covered		50%	
Endodontics	50%; pulpotomies on primary teeth only		50%	
Periodontics	Not covered		50%	
Prosthodontics	50%; stainless steel crowns on primary teeth only		50%	
Orthodontics	Not covered		Children only: 50%; $100 deductible; $500 per year; $1,000 lifetime maximum	
Waiting Periods	None for cleanings, exams and X-rays; 6 months for all other covered services		None for cleanings, exams and X-rays; 6 months for basic services; 12 months for major services/orthodontics	

Dental Blue PPO is offered by Anthem Blue Cross Life and Health Insurance Company and Dental SelectHMO is offered by Anthem Blue Cross.

Term Life Insurance

Losing a loved one is painful enough without having to worry about finances. Give your family extra support with term life insurance from Anthem Blue Cross Life and Health Insurance Company.

If you're accepted for coverage on one of our health care plans, you'll automatically be approved for our term life insurance. Plus, there are no medical exams or additional enrollment forms to worry about. It's that simple.

Term Life Monthly Rates

Age	$15,000 Benefit	$30,000 Benefit	$50,000 Benefit	$75,000 Benefit	$100,000 Benefit
1-18	$1.50	$3.00	N/A	N/A	N/A
19-29	$2.80	$5.60	$9.30	$11.25	$13.00
30-39	$3.25	$6.50	$10.80	$13.50	$16.00
40-49	$7.50	$15.00	$25.00	$33.75	$42.00
50-59	$20.90	$41.80	$69.60	$97.50	$125.00
60-64	$29.40	$58.80	$98.00	$142.50	$185.00

Additional information

"No Obligation" review period

After you enroll in a plan offered by Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company, you will receive a Policy/EOC booklet that explains the exact terms and conditions of coverage, including the plan's exclusions and limitations. You will have 10 days to examine your plan's features. During that time, if you are not fully satisfied, you may decline by returning your Policy/ EOC booklet along with a letter notifying us that you wish to discontinue coverage. Policy/EOC booklets are available for you to examine prior to enrolling. Ask your agent or Anthem Blue Cross.

Save time with automatic premium payments

Hate writing checks? After your initial payment, our Electronic Fund Transfer (EFT) program will automatically withdraw funds from your bank account each month to pay for your health plan premium. You'll not only save on postage, you won't have to worry about a lapse in coverage because you forgot to mail in your payment. To sign up, just fill out the billing section of the enrollment application.

Ready to choose a plan?

- After reviewing all the materials included with this brochure, contact your Anthem Blue Cross agent.
- Ask questions. If you aren't sure about how a plan works or have additional questions, your agent will help you.
- Fill out an application. The quickest and easiest way to complete an application is online and your agent can assist you. Or your agent can provide you with instructions for mailing or faxing your application.

Anthem BlueCross

Individual health coverage. Your plans. Your choices.

Make sure you have all the facts.

This brochure is only one piece of your plan information. Please make sure you have all the facts about the benefits offered by the plan(s) described — including what's covered, and what isn't. For additional information about exclusions, limitations, and terms of this coverage, please see the enclosed Coverage Details. This document should be included with your information kit, or if you have printed this from your computer, it should be at the end of this document. If you don't have this document, be sure to contact your Anthem Blue Cross agent.

This brochure is intended as a brief summary of benefits and services; it is not your Policy. If there is any difference between this brochure and your Policy, the provisions of the Policy will prevail. Benefits and premiums are subject to change.

This summary of benefits complies 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.

Ready to enroll?

Call your Anthem agent today!

To view a Summary of Benefits and Coverage please visit healthcare.gov.

Stay focused on your fitness.

Anthem BlueCross

Let ACS | BNY Mellon handle the finances.

You're only one checkmark away

Simply make the selection on your application form. We'll take care of setting up your account. We'll also take care of sending you a Welcome Kit to get you started. All you have to take care of is your health. Which is, after all, the most important thing.

Setting up a Health Savings Account

The Lumenos® HSA plans are a nice way to save on premiums. But that's just the tip of the savings iceberg. To realize your plan's full financial power, consider opening a health savings account to go with your Lumenos plan. The portability and tax savings of an HSA account can add up fast.

We've joined with Affiliated Computer Services (ACS) and The Bank of New York Mellon (BNY Mellon) to integrate their HSA accounts with our Lumenos HSA plans. Setting up your account with BNY Mellon is easy. Plus, it comes with built-in advantages and conveniences:

- A single customer service contact for the health plan and your HSA
- A single online health site to access your plan benefit information and account details
- Several payment and deposit options, including special checks and automatic fund transfers
- Competitive interest rates and investment opportunities for the funds in your account

Of course, if you'd rather use another financial institution for your account, that's fine too.

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A closer look

HSA Welcome Kit

If you make the selection on your application form, your Health Savings Account will automatically be set up once you're approved for the Lumenos HSA plan — no set up fee required, and you'll soon receive an HSA Welcome Kit. In it, you'll find all of the banking documentation and instructions for using your account. A separate application for your account is only required if you choose a financial institution other than BNY Mellon.

This is what the IRS requires if you want to open a Health Savings Account:

- You must be covered by an HSAcompatible high deductible health plan (such as the Lumenos HSA plan).
- You must be a U.S. resident, and not a resident of Puerto Rico or American Samoa.
- You cannot be covered by any other medical plan that is not an HSA-compatible high deductible health plan.
- You cannot be enrolled in Medicare.
- You cannot be claimed as a dependent on another individual's tax return.
- If you are a veteran, you may not have received veteran's benefits within the last three months.
- You cannot be active military.

Interest and investments

You'll earn interest on your HSA funds and have the chance to invest your funds as long as you keep a minimum $1,000 HSA balance. Investment options include a number of mutual families. Once you're ready to invest, just call the ACS | BNY Mellon HSA Solution Contact Center at **866-686-4798** Monday through Friday from 8 a.m. to 8 p.m. (Eastern Time) for a prospectus with more details.

Debit cards, checkbooks and online banking

Use your MasterCard® debit card, your HSA checkbook, or our new online banking option (provided by BNY Mellon) to pay your health care provider or pharmacy directly for eligible medical expenses, or to get cash from your account.

Deposits to your account

To contribute to your HSA, simply send a check and deposit slip to the address printed on your HSA checkbook. Or you can set up an electronic funds transfer between your bank and BNY Mellon for regular account contributions.

Account activity statements

Each month, you'll receive a statement from BNY Mellon that shows all of your account activity. For an additional fee of $0.75 per month, you can receive a paper statement. Please go to anthem.com or call your dedicated Customer Service to learn how to elect this option. You'll also receive IRS 1099 and IRS 5498 forms from BNY Mellon near tax time to help with tax preparation.

ACS | BNY Mellon HSA fee and rate schedule

A Deposit Agreement and a Disclosures and Fee Sheet will be in your HSA Welcome Kit. Please refer to those documents for the complete terms and conditions related to your account.

As good as these options may sound, you should still talk to your tax advisor when trying to maximize financial benefits for your personal situation.

Banking fees	
Monthly account fee	$2.95
First 2 debit cards	no charge
Debit card transactions	no charge
Check writing	no charge
ATM transactions	$1
Card replacement	$5
Check reorder	$10
Non-sufficient funds	$25
Stop check service	$25
Duplicate check	$5
Periodic paper statement	$0.75

California Coverage Details

Things you need to know before you buy...

Anthem BlueCross

ClearProtection℠, CoreGuard℠ Plus, Lumenos® HSA Plus, Premier Plus, SmartSense®Plus, Tonik®, PPO Share, HMO Saver, Individual HMO, Select HMO

Before choosing a health care plan, please review the following information, along with the other materials enclosed.

To Enroll, You And Your Dependents Must Be:

- Age 64¾ or younger
- A permanent legal resident of California
- A U.S. resident for at least the last 3 months
- The applicant's spouse or domestic partner, age 64¾ or younger
- The applicant's children (under 26 years of age), or the children (under 26 years of age) of the applicant's enrolling spouse or qualified domestic partner
- The applicant's child (of any age) who is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition and is chiefly dependent upon the applicant for support and maintenance

Medical Underwriting Requirement

We believe that the cost of our plans should be consistent with your expected health care needs and risk factors. That's why Anthem offers various levels of coverage. To determine individual medical risk factors, all applications are subject to medical underwriting. Depending on the results of the underwriting review, a number of things may happen:

- You may be offered coverage at the standard premium charge
- You may be offered the plan you selected at a higher rate
- You may not qualify for the plan listed in this brochure
- You may be offered an alternate plan

If you have a significant medical condition and do not qualify for the plan you've chosen or if you have discontinued group coverage, please contact your Anthem representative for information regarding other Individual coverage options.

Important Information for Applicants Under the Age of 19

As provided by California AB 2244 (2010), an applicant under the age of 19 may be assessed a 20% surcharge for the 12-month period following the effective date of enrollment. The surcharge would apply if the applicant has not had continuous coverage during the 90 day period prior to the date of application and is not a late enrollee. If applying for coverage outside of the birthday month or a special late enrollee period, a higher rate may apply.

Medical Loss Ratio

As required by law, we are advising you that Anthem Blue Cross' medical loss ratio for 2011 was 80.9 percent. The 2011 medical loss ratio for Anthem Blue Cross Life and Health Insurance Company was 79.9 percent. These ratios were calculated after provider discounts were applied and based on state and federal regulatory rules and regulations including the federal MLR regulations.

Waiting Periods

For applicants age nineteen (19) and older, there is a specific six-month waiting period for coverage of any condition, disease or ailment for which medical advice or treatment was recommended or received within six months preceding the effective date of coverage. If you apply for coverage within 63 days of terminating your membership with another "creditable" health care plan, then you can use your prior coverage for credit toward the six-month waiting period. Anthem will credit the time you were enrolled on the previous plan. The pre-existing condition limitation does not apply to applicants under age nineteen.

Access To The MIB

In accordance with federal and state privacy laws, Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company or its reinsurers may, obtain and disclose personal health information to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

You may have an MIB record if you have applied for individual insurance (life, health, disability income, long-term care or critical illness insurance) in the last seven years with a MIB Member company. You may obtain a free copy of your MIB file annually, if one exists, upon request, and subject to proper identification, by contacting MIB at 866-692-6901 (TTY 866-346-3642). If after receipt and review of your MIB file, you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act and applicable state law.

The address of MIB's Information Office is:
50 Braintree Hill Park, Suite 400
Braintree, MA 02184-8734.

Information for consumers about MIB may be obtained on its website at www.mib.com.

Utilization Management and Case Management

Our Utilization Management (UM) services offer a structured program that monitors and evaluates member care and services. The UM clinical team, which is made up of health care professionals who hold active professional licenses and certificates, perform the prior authorization, concurrent and retrospective review processes explained below. The UM team follows criteria to assist in decisions regarding requests for health care and other covered benefits, and complies with specific timeframes to ensure requests are handled in a timely manner. Our case management services help you to better understand and manage your health conditions.

Prospective Review/Pre-Admission Review

Prospective review (also known as pre-service or pre-admission review) is the process of reviewing a request for a medical procedure or service before it takes place. The review occurs to ensure that: 1) the procedure is medically necessary and 2) the procedure meets your health care plan's specific guidelines prior to being performed. Requests for prospective review may include but are not limited to:

- inpatient hospitalizations
- outpatient procedures
- diagnostic procedures
- therapy services, including therapy for Pervasive Developmental Disorders
- durable medical equipment

Prospective review is required for all elective inpatient admissions and certain outpatient services. The review process evaluates medical necessity and the best level of care and assigns expected length of stay if needed.

Concurrent Review

Concurrent review is an ongoing evaluation of a member's hospital stay, as well as ongoing extensions of services that may be needed (such as acute care facilities, skilled nursing facilities, acute rehabilitation facilities, and home health care services). The review includes physicians, member-assigned health care professionals (or member authorized representative) and takes place by telephone, electronically and/or onsite.

Concurrent review uses pre-set decision criteria in order to approve medical care (deemed to be medically necessary) and assign the right level of care for continued medical treatment. Review decisions are based on the medical information obtained at the time of the review. Concurrent review also helps to coordinate care with behavioral health programs.

Retrospective Review

The retrospective review process consists of obtaining information to determine medical necessity as it relates to services provided without approval or notice ahead of time (e.g. without pre-service notification). Relevant clinical information is required for the retrospective review process. Review decisions are based only on the medical information the doctor or other provider had at the time the member received medical care.

Case Management

Case managers are licensed healthcare professionals who work with you to help you understand your benefits and support your health care needs. The case manager works with you and your doctor to help you better understand and manage your health conditions.

What Individual Health Care Plans Do Not Cover

The following overview will help you understand what your health care plan does not include before you enroll. For a comprehensive list of the plans' exclusions and limitations, you can request a copy of the Policy/ Evidence of Coverage (EOC).

Medical Exclusions And Limitations

Exclusions

- Conditions covered by workers' compensation or similar law
- Experimental or investigative services
- Services provided by a local, state or federal government, unless you have to pay for them
- Durable Medical Equipment, except as specifically stated in the policy
- Services or supplies not specifically listed as covered under the Policy/EOC
- Services received before your effective date or after coverage ends
- Services you wouldn't have to pay for without insurance
- Services from relatives
- Any services received by Medicare benefits without payment of additional premium
- Services or supplies that are not medically necessary
- Routine physical exams (e.g., physical exams for insurance, employment, licenses or school are not covered), except for preventive care services specifically stated in the Policy/EOC.
- Sex changes
- Cosmetic surgery
- Services primarily for weight reduction except medically necessary treatment of morbid obesity
- Dental care, dental implants or treatment to the teeth, except as specifically stated in the Policy/EOC
- Orthodontic services, braces, and other orthodontic appliances
- Hearing aids
- Infertility services
- Private duty nursing
- Eyeglasses or contact lenses, except as specifically stated in the Policy/EOC
- Vision care including certain eye surgeries to replace glasses, except as specifically stated in the Policy/EOC
- Specialty drugs from a pharmacy other than our specialty drug provider
- Certain orthopedic shoes or shoe inserts, except as specifically stated in the Policy/EOC
- Services or supplies related to a pre-existing condition, for applicants age nineteen and older
- Outdoor treatment programs
- Telephone, facsimile machine and electronic mail consultations
- Educational services except as specifically provided or arranged by Anthem
- Nutritional counseling, food or dietary supplements, except for formulas and special food products to prevent complications of phenylketonuria (PKU)
- Personal comfort items
- Custodial care
- Outpatient speech therapy, except as specifically stated in the Policy/EOC
- Certain genetic testing
- Services or supplies provided to any person not covered under the Agreement in connection with a surrogate pregnancy

Medical Exclusions and Limitations (continued)

Limitations

Acupuncture and Acupressure:

- ClearProtection Plus, CoreGuard Plus, Premier Plus, SmartSense Plus and Tonik: Not Covered
- Lumenos HSA Plus or PPO Share: 24 visits per calendar year. All visit limits for Acupuncture and Acupressure are combined and apply to the visit limit.

Physical Therapy, Occupational Therapy and Chiropractic Services:

- CoreGuard Plus, Lumenos HSA Plus, PPO Share, Premier Plus or Tonik: 24 visits per calendar year. All visit limits for Physical Therapy, Occupational Therapy and Chiropractic Services are combined and apply to the visit limit.

Physical Therapy and Occupational Therapy Services:

- ClearProtection: 24 visits per calendar year. All visit limits for Physical Therapy and Occupational Therapy are combined and apply to the visit limit. Chiropractic services are not covered.

Physical Therapy, Occupational Therapy and Speech Therapy Services:

- SmartSense Plus: 24 visits per calendar year. All visit limits for Physical Therapy, Occupational Therapy and Speech Therapy are combined and apply to the visit limit.

Chiropractic Services

- SmartSense Plus: 20 visits per calendar year

Mental or Nervous Disorders and Substance Abuse:
(This does not include the treatment for Severe Mental Illness and Serious Emotional Disturbances of a Child)

- Inpatient
  - ClearProtection: Not covered
  - CoreGuard Plus, Lumenos HSA Plus, Premier Plus, SmartSense Plus, Tonik or PPO Share: 30 days per calendar year
- Outpatient
  - ClearProtection: Not covered
  - Lumenos HSA Plus, SmartSense Plus, Tonik or PPO Share: 1 visit per day, 20 visits per calendar year
  - CoreGuard Plus or Premier Plus: 1 visit per day, 48 visits per calendar year.

In addition the **Individual HMO, HMO Saver and Select HMO** plans do not cover:

- Care not authorized by your Primary Medical Group or Independent Practice Association
- Amounts in excess of customary and reasonable charges for care rendered by a non-participating provider without a referral from your PMG or IPA
- Chiropractic services
- Immunizations for foreign travel
- Treatment for chronic alcoholism or other substance abuse except as specifically stated in the Evidence of Coverage
- Inpatient mental care, including acute alcoholism and drug addiction benefits, except detoxification
- Treatment of mental and nervous disorders, except as specifically stated in the Evidence of Coverage

Limitations

- Rehabilitative care specifically stated in the Evidence of Coverage
- Reconstructive surgery, purchase or replacement of artificial limbs or prosthesis except as specifically stated in the Evidence of Coverage
- Medical, surgical and/or psychological treatment of a sexual dysfunction, except when a sexual dysfunction is a result of a physical abnormality, defect or disease
- Medical, surgical services, supplies or treatment to the joint of the jaw (temporomandibular joint), upper jaw (maxilla) or lower jaw (mandible), unless related to a tumor or accident occurring while covered
- Routine physical examinations or tests that do not directly treat an acute illness, injury or condition unless authorized by your Primary Care Physician, except in no event will any physical examination or test required by employment or government authority, or at the request of a third party, such as a school, camp or sports-affiliated organization, be covered unless medically necessary

Dental Blue® PPO Limitations And Exclusions

Limitations

This is a partial list of plan limitations. Please see the Individual Dental Plan Contract for a complete list.

- Oral Evaluations: Limited to two per calendar year
- Routine Cleaning or Periodontal Cleaning: Limited to two treatments per calendar year
- Fluoride: Fluoride treatment limited to two per calendar year for children up to age 19
- X-rays: Limited to one set of full-mouth X-rays or its equivalent in a five-year period
- Periapical X-rays: Limited to four films per year
- Bitewing X-rays: Limited to one set of up to four films twice per calendar year
- Sealants: Limited to children under 16 years of age for permanent unrestored first and second molars
- Treatment is limited to one application per tooth per lifetime
- Space Maintainers: Limited to once per quadrant per lifetime for children up to age 16. Includes all adjustments within six months of placement
- Restorations: Limited to once per surface per tooth every 24 months
- Periodontal Scaling: Limited to once per quadrant every 24 months
- Periodontal Surgery: Limited to one time per quadrant in a 36-month period
- Root Canal Therapy: Limited to one treatment per tooth for initial treatment and one retreatment per tooth — for permanent teeth only
- Stainless Steel Crowns: Limited to baby teeth only. Once per tooth in any five years
- Crowns: Limited to once per tooth in any five years
- Removable, Partial and Complete Dentures: Limited to once in five years. Benefits are payable for either complete or immediate dentures, but not both
- General Anesthesia: Covered only when used in conjunction with covered oral surgical procedures

Exclusions

This is a partial listing of plan exclusions. Please see the Individual Dental Plan Contract for a complete list.

- Prescribed drugs, pre-medication or analgesia including charges for nitrous oxide or any similar local anesthetic when the charge is made separately
- Occlusal guards
- Bleaching of non-vital discolored teeth
- Crown buildups on the same tooth as an amalgam or composite restoration that was done within the same calendar year
- Procedures to alter, restore or maintain occlusion, change vertical dimension, and replace or stabilize tooth structure lost by attrition, abrasion, erosion or bruxism
- Harmful habit appliances
- Services related to diagnosis or treatment related to the temporomandibular joint (TMJ)
- Dental implants and all adjunctive services performed in conjunction with the placement or removal of implants including but not limited to surgery, cleanings, maintenance and prosthetics placed on implants
- Infection control procedures, if billed separately
- Precision attachments
- Prefabricated resin crown or stainless steel crown with resin window
- Pulpotomy on permanent teeth
- Replacement of a prosthodontic appliance (fixed or removable) more often than once in any five-year period, whether under this contract or under any prior dental coverage
- Root canal therapy on baby teeth
- Sealants on restored teeth (occlusal surface)
- Temporary/interim prosthodontia or appliances (temporary crowns, bridges, partials, dentures, etc.)
- Biopsies
- Services or supplies not specifically listed in the covered services section of the Individual Dental Plan Contract

Dental SelectHMO Limitations And Exclusions

This is a partial listing of plan limitations and exclusions. Please see the Contract for a complete list.

- Experimental or investigative care or therapy
- Any condition for which benefits of any nature are recovered or found to be recoverable, whether by adjudication, settlement or otherwise, under any workers' compensation or occupational disease law, even if you do not claim these benefits. If there is a dispute or substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers' compensation, Anthem Blue Cross Life and Health Insurance Company will provide the plan benefits for such conditions subject to its right of recovery and reimbursement under California Labor Code Section 4903
- Any services for which you are entitled to receive Medicare benefits, whether or not Medicare benefits are actually paid
- Any services provided by a local, state, county or federal government agency, including any foreign government, except when payment under the plan is expressly required by federal or state law
- Services or supplies for which no charge is made, or for which no charge would be made if you had no insurance coverage, or services for which you are not legally obligated to pay
- Services received before your effective date or during an inpatient stay that began before your effective date
- Services rendered before coverage begins or after coverage ends
- Prescribed drugs, pre-medication or analgesia (including nitrous oxide)
- No benefits are provided for hospital or associated physician charges for any dental treatment that cannot be performed in the dentist's office because of your general health, mental, emotional, behavioral or physical limitations
- Unless an exception is specifically authorized by Anthem Blue Cross in writing, dental services must be received from your participating dentist or participating specialty dentist
- A dental treatment plan, which in the opinion of the participating dentist and/or Anthem Blue Cross is not dentally necessary for dental health or will not produce beneficial results
- Conditions caused by the inadvertent release of nuclear energy when government funds are available for treatment of illness or injury arising from such release of nuclear energy
- Treatment of fractures or dislocations
- Any treatment to correct a dental condition that resulted from dental services performed by a non-participating dentist while coverage is in effect and any dental services started by a non-participating dentist will not be the responsibility of the participating dentist or Anthem Blue Cross for completion
- Histopathological exams and/or the removal of tumors, cysts, neoplasms and foreign bodies not covered under the medical plan
- Teeth with questionable, guarded or poor prognosis are not covered for endodontic treatment, periodontal surgery or crown and bridge. Plan will allow for observation or extraction and prosthetic replacement
- Services received after the benefit limit under this agreement is reached
- Orthodontic services must be received from a participating orthodontist. In the event of loss of coverage for any reason, and at the time of loss of coverage you are still receiving orthodontic treatment, you will be responsible for the remainder of the cost for that treatment
- Replacement of lost or stolen orthodontic appliances or repair of orthodontic appliances that were broken due to negligence
- Myofunctional therapy and related services
- Surgical procedures incidental to orthodontic treatment, including but not limited to extraction of teeth solely for orthodontic reasons, exposure of impacted teeth, correction of micrognathia or macrognathia, or repair of cleft palate
- Changes in treatment necessitated by an accident of any kind
- Treatment related to the joint of the jaw (temporomandibular joint, TMJ) and/or hormonal imbalance

Anthem BlueCross

This document provides a brief summary of provisions and does not include the full extent of exclusions and limitations. If there is any difference between this document and the Policy, the Policy will prevail. We want you to understand what your coverage does not include before you enroll. The Policy/Evidence of Coverage booklets contain a comprehensive list of the plans' exclusion and limitations which you should read before you enroll. For a sample copy of the Policy/Evidence of Coverage booklet, ask your agent or contact Anthem Blue Cross.

This summary of benefits provided in the enclosed brochure complies 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 the summary of benefits in the brochure.

Selecting health coverage is an important decision.

To assist you, we are also providing you with the Brochure and Enrollment Application. If you did not receive one or more of these materials, please contact your Anthem Blue Cross agent to request them.

The Policy/Evidence of Coverage booklets are also available for you to examine before enrolling. Ask your agent or Anthem Blue Cross.