Clip on Radio/Flashlight

Only 250 points!

Our clip on radio includes all your favorites. A flashlight, carabiner clip, FM auto-scan radio, compass, and ear buds.

Batteries included.

GET YOUR REWARDS!
Register at anthemrewards.com!

BE REWARDED FOR STAYING ACTIVE!

SEE THE "GET THE MOST FROM YOUR HEALTH BENEFITS" SECTION OF THIS BOOKLET FOR MORE INFORMATION.

Check with your physician before starting any new exercise program, especially if you have a medical problem, haven't exercised recently or are over the age of 40.

In Connecticut, Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans, Inc., in New Hampshire, Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of New Hampshire, Inc. In Maine, Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Maine, Inc. Independent licensee of the Blue Cross and Blue Shield Association. "Anthem" is a registered mark of Anthem Insurance Companies, Inc.
Benefits You Can Count On

Any health insurance company can say it cares. How many actually prove it?

At Anthem Blue Cross and Blue Shield, we demonstrate our commitment to good health. This book discusses many of the ways we help. For instance, with your health plan you’ll have:

1. **preventive benefits**
   You’ll have coverage for preventive care to help you stay your healthiest. Benefits are available for physical exams, health screenings, childhood immunizations, well-baby care and gynecological visits.

2. **easy access to medical providers**
   You’ll have a wide range of network physicians, hospitals and other health care providers to choose from when you receive covered medical services in the state where you live.

3. **coverage for emergencies**
   You’ll have coverage for serious and life-threatening situations – *anywhere*. And, because of our relationship with other Blue Cross and Blue Shield plans, you’ll have coverage for urgent health situations when they occur. It’s peace of mind when you need it most.
HMO Choice (POS)

**HMO Choice lets you choose whether to receive care from an extensive network of providers, or from physicians outside the network.**

**HMO Choice** is a point-of-service health plan. That means you can receive the highest level of benefits when you use any of the more than 4,000 physicians, hospitals and other health care professionals in the plan network. You can also receive care from providers that are not part of the network, however your out-of-pocket costs will be greater.

**Find a Doctor – at anthem.com**

An online list of participating providers is available at [anthem.com](http://anthem.com). This directory is updated weekly. You can search for a network provider by location, specialty and languages spoken.

> To find a participating provider or hospital in the Maine network, go to:
> [anthem.com](http://anthem.com) > Find a Doctor > Select Maine > Select Plan and either Provider Type, Name or Specialty > Follow Search Options

> To find a participating provider or hospital elsewhere in the U.S., be sure to have your member ID card handy and then go to:
> [anthem.com](http://anthem.com) > Find a Doctor > Select National Directories (choose BlueCard® to locate a physician or hospital) > Select Physician or Hospital > Select POS Plan (then follow the instructions on the screen)

If you’re already an Anthem member, call the customer service number on your ID card for assistance in locating a participating provider.

**HMO Choice (POS) at a Glance**

- Primary care physician (PCP) required
- Referral needed to see a specialist in the provider network
- Benefits for care from non-network providers (greater out-of-pocket costs)
- Extensive local provider network
- No claim forms to submit when using network providers
- Coverage for a wide range of services
  - Routine preventive care
  - Well-child care
  - Immunizations
  - Inpatient & outpatient care
  - Emergency care
- Access to discounts through SpecialOffers@Anthem®
- Prescription drug coverage available (varies by plan selected)

**Understanding the Terminology**

Anthem Blue Cross and Blue Shield pays the majority of your health care expenses. The specific amount that you pay depends on the plan you select and the deductible you choose. Your total out-of-pocket expenses include:

- **Deductible**: The amount that you pay each calendar year for covered services before your health benefit plan begins paying for covered expenses.
- **Coinsurance**: The percentage of covered expenses that you pay once you have met the deductible.
- **Copayment (copay)**: A fixed dollar amount you pay when a covered service is provided.
### University of Maine System
#### HMO Choice Point of Service Plan
##### Benefit Overview
Effective January 1, 2006

<table>
<thead>
<tr>
<th>HMO Choice – Point of Service Coverage</th>
<th>Highest Level of Benefits</th>
<th>Self-referred Level of Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Important Information</td>
<td>Benefits are based on our maximum allowance for covered services. Our maximum allowance is the most we will pay for a particular service. Coverage described in this column applies when covered services are provided or authorized by your Primary Care Physician, unless otherwise stated. You are responsible for any copayments and coinsurance that apply.</td>
<td>Benefits are based on our maximum allowance for covered services. Our maximum allowance is the most we will pay for a particular service. Coverage described in this column applies when you self-refer to providers or professionals. (The Primary Care Physician does NOT provide or authorize services.) You may be responsible for filing claims and paying balance bills in addition to the deductible, copayments, and coinsurance. You may also need to pay the provider or professional up front.</td>
</tr>
<tr>
<td>Inpatient Admission Review</td>
<td>Scheduled inpatient admissions, except for planned cesarean sections, require preadmission authorization by the Primary Care Physician. For emergency admissions, you should call your Primary Care Physician within 48 hours after admission.</td>
<td>For scheduled inpatient admissions, except for planned cesarean sections, you or someone you designate must call 1-800-392-1016 for preadmission review. If you self-refer and do NOT call for review before admission, benefits can be reduced by up to $500. The $500 penalty does not apply to emergency admissions. For emergency admissions, you or someone you designate should call within 48 hours after admission. For maternity admissions, you or someone you designate must call if the hospital stay is longer than 48 hours for a normal vaginal delivery or longer than 96 hours for a cesarean section.</td>
</tr>
<tr>
<td>Calendar Year Deductible</td>
<td>None</td>
<td>$250 per member/ $500 per family</td>
</tr>
</tbody>
</table>

HMO Choice – 3 tier
<table>
<thead>
<tr>
<th></th>
<th>Highest Level of Benefits</th>
<th>Self-referred Level of Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Coinsurance</strong></td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>Calendar Year Out-of-pocket Limit (Deductible + Coinsurance)</strong></td>
<td>None (except for infertility)</td>
<td>$ 2,500 per member $ 5,000 per family</td>
</tr>
<tr>
<td><strong>Lifetime Maximum Benefits</strong></td>
<td></td>
<td>$ 1,000,000</td>
</tr>
<tr>
<td><strong>Hospital Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Inpatient &amp; Outpatient)</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Emergency Room Care</strong></td>
<td>$ 25 copayment, then 100%. For emergency services you should seek immediate medical care. If you are admitted to the hospital from the emergency room, the copayment is waived.</td>
<td>$ 25 copayment, then 100%. For emergency services you should seek immediate medical care. If you are admitted to the hospital from the emergency room, the copayment is waived.</td>
</tr>
<tr>
<td><strong>High Tech Diagnostic Radiology (including but not limited to, CT Scans, MRI/MRAs, Nuclear Cardiology, PET Scans. These services require prior authorization.</strong></td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Professional Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient &amp; Outpatient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Office Visits:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sick Care</td>
<td>100% after a $20 copayment</td>
<td>80%</td>
</tr>
<tr>
<td>Routine/Preventive</td>
<td>100% after a $20 copayment</td>
<td>Not covered</td>
</tr>
<tr>
<td>Well Baby/Child Care</td>
<td>100% after a $20 copayment</td>
<td>Not covered</td>
</tr>
<tr>
<td>Maternity Care:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre &amp; Postnatal</td>
<td>100% after a $20 copayment for first visit 100%</td>
<td>80%</td>
</tr>
<tr>
<td>Delivery</td>
<td></td>
<td>80%</td>
</tr>
<tr>
<td>Routine Gynecological Exam</td>
<td>100% after a $20 copayment (No PCP referral required)</td>
<td>100% after a $20 copayment (Not covered if you self-refer to a non-participating professional.)</td>
</tr>
<tr>
<td><strong>Family Planning Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Exam, Laboratory Tests, Information &amp; Counseling</td>
<td>100% after a $20 copayment</td>
<td>80%</td>
</tr>
<tr>
<td>Insertion/Removal of IUD</td>
<td>100% after a $20 copayment</td>
<td>80%</td>
</tr>
<tr>
<td>Insertion/Removal of Norplant</td>
<td>100% after a $20 copayment</td>
<td>80%</td>
</tr>
<tr>
<td>Diaphragm</td>
<td>100% after a $20 copayment</td>
<td>80%</td>
</tr>
<tr>
<td>Vasectomy</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Elective Tubal Ligation</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Reverse Sterilization</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Abortion</td>
<td>100%</td>
<td>80%</td>
</tr>
</tbody>
</table>

(No PCP referral required)
<table>
<thead>
<tr>
<th>Service</th>
<th>Highest Level of Benefits</th>
<th>Self-referred Level of Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infertility Services</td>
<td>50%</td>
<td>Not covered</td>
</tr>
<tr>
<td><em>See Certificate of Coverage for limitations</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic Services</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Physical &amp; Occupational Therapy</td>
<td>100% after a $20 copayment</td>
<td>80%</td>
</tr>
<tr>
<td><em>Combined limit of $3,000 per calendar year for physical, occupational, and speech therapy</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speech Therapy</td>
<td>100% after a $20 copayment</td>
<td>80%</td>
</tr>
<tr>
<td><em>Combined limit of $3,000 per calendar year for physical, occupational, and speech therapy</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiac Therapy</td>
<td>100% after a $20 copayment</td>
<td>80%</td>
</tr>
<tr>
<td></td>
<td><em>3 sessions per week, up to 24 sessions per calendar year</em></td>
<td></td>
</tr>
<tr>
<td>Chiropractic Care</td>
<td>100% after a $20 copayment</td>
<td>80%</td>
</tr>
<tr>
<td></td>
<td>No referral required for up to 36 visits in a calendar year to a network professional</td>
<td></td>
</tr>
<tr>
<td></td>
<td>100% after a $20 copayment</td>
<td>80%</td>
</tr>
<tr>
<td></td>
<td>(first 36 visits in a calendar year to a network chiropractor, 80% for visits to a non-network professional or over 36 visits in a calendar year)</td>
<td></td>
</tr>
<tr>
<td>Routine Eye Exam</td>
<td>100% after a $20 copayment</td>
<td>100%</td>
</tr>
<tr>
<td><em>One routine eye exam every calendar year up to age 19. One routine eye exam every two calendar years thereafter.</em></td>
<td></td>
<td><em>100% after a $20 copayment (no PCP referral required)</em></td>
</tr>
<tr>
<td></td>
<td>Not covered if you self-refer to a non-participating professional</td>
<td></td>
</tr>
<tr>
<td>Allergy Testing/Injections</td>
<td>100% after a $20 copayment</td>
<td>80%</td>
</tr>
<tr>
<td>Private Duty Nursing</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td><em>Preapproval required</em></td>
<td></td>
<td><em>Up to $2,500 per calendar year</em></td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td></td>
<td><em>100 days per calendar year</em></td>
<td></td>
</tr>
<tr>
<td>Home Health Care</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td><em>Preapproval required</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospice</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td><em>(Prosthetics to replace limbs are not subject to the limit or deductible)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>$3,000 annual maximum for both benefit levels combined</em></td>
<td></td>
</tr>
<tr>
<td>Smoking Cessation</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Smoking Cessation Program</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td><em>Up to $35 per program; $70 per lifetime</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medications prescribed by a physician</td>
<td>Prescription drug copayment applies</td>
<td>Prescription drug copayment applies</td>
</tr>
<tr>
<td>Physician Follow-up Visits/Counseling</td>
<td>100% after a $20 copayment</td>
<td>80%</td>
</tr>
</tbody>
</table>
### Mental Health and Substance Abuse

(Managed by Anthem Behavioral Health and all services require preauthorization.) Failure to comply with the requirements outlined in your Certificate of Coverage may result in a penalty up to $500.

<table>
<thead>
<tr>
<th>Highest Level of Benefits</th>
<th>Self-referred Level of Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>This coverage level applies when the member obtains preauthorization from Anthem Behavioral Health (1-800-755-0851) for all inpatient and outpatient mental health and substance abuse services, AND receives those services from the provider that the mental health care manager indicates.</td>
<td>This coverage level applies when the member does NOT contact Anthem Behavioral Health (1-800-755-0851) for preauthorization of mental health and substance abuse services OR chooses to receive services from a provider other than the provider the mental health care manager indicates. (The member may have to pay balance bills in addition to deductible and coinsurance amounts.)</td>
</tr>
</tbody>
</table>

*Listed Mental Illnesses: State of Maine Statute requires that benefits be provided at the same benefit level provided for medical treatment for the following listed mental illnesses:

- Psychotic disorders, including schizophrenia; dissociative disorders; mood disorders; anxiety disorders; personality disorders; paraphilias; attention deficit and disruptive behavior disorders; pervasive developmental disorders; tic disorders; eating disorders, including bulimia and anorexia; and substance abuse-related disorders.

**Mental Health Services**

*Listed mental illnesses including substance abuse services:

<table>
<thead>
<tr>
<th>Service</th>
<th>Highest Level of Benefits</th>
<th>Self-referred Level of Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>100%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Day Treatment</td>
<td>100%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Outpatient</td>
<td>100%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Hospital Emergency Room</td>
<td>$25 copayment, then 100%</td>
<td>$25 copayment, then 100%</td>
</tr>
<tr>
<td>Office Visits</td>
<td>$20 copayment, then 100%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Home Health Care Services</td>
<td>100%</td>
<td>80% after deductible</td>
</tr>
</tbody>
</table>

**Non listed mental illnesses:**

<table>
<thead>
<tr>
<th>Service</th>
<th>Highest Level of Benefits</th>
<th>Self-referred Level of Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>80%</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>Up to a combined limit of 60 days per member per calendar year</strong></td>
<td>Two days of day treatment equal one day of inpatient services.</td>
<td>Two days of day treatment equal one day of inpatient services.</td>
</tr>
<tr>
<td>Outpatient</td>
<td>50%</td>
<td>30% after deductible</td>
</tr>
<tr>
<td><strong>Up to a combined limit of 40 visits per member per calendar year.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Health Care Services</td>
<td>100%</td>
<td>80% after deductible</td>
</tr>
</tbody>
</table>

Two days of day treatment equal one day of inpatient services.

60% after deductible

80% after deductible
**Prescription Drug Coverage (3 Tier Benefit)**

**Note:** Primary Care Physician authorization is not required.

<table>
<thead>
<tr>
<th>Generic Drugs:</th>
<th>Retail Pharmacy</th>
<th>Optional Brand Name Drugs: *</th>
</tr>
</thead>
<tbody>
<tr>
<td>You pay a:</td>
<td>You pay a:</td>
<td>You pay a:</td>
</tr>
<tr>
<td>$10 copayment</td>
<td>$25 copayment</td>
<td>$40 copayment for up to a 30-day supply,</td>
</tr>
<tr>
<td>for up to a 30-day supply,</td>
<td>for up to a 30-day supply,</td>
<td>$80 copayment for up to a 60-day supply,</td>
</tr>
<tr>
<td>$20 copayment</td>
<td>$50 copayment</td>
<td>$120 copayment for up to a 90-day supply.</td>
</tr>
<tr>
<td>for up to a 60-day supply,</td>
<td>for up to a 60-day supply,</td>
<td></td>
</tr>
<tr>
<td>$30 copayment</td>
<td>$75 copayment</td>
<td></td>
</tr>
<tr>
<td>for up to a 90-day supply.</td>
<td>for up to a 90-day supply.</td>
<td></td>
</tr>
</tbody>
</table>

**Mail Service Pharmacy**

**Generic Drugs:** You pay a $20 copayment for up to a 90-day supply.

**Brand Name Drugs**: You pay a $50 copayment for up to a 90-day supply.

**Optional Brand Name Drugs**: You pay a $80 copayment for up to a 90-day supply.

Certain Maine retail pharmacies can fill your prescription at the same copayments that apply to the mail service pharmacy level of benefits. Please ask your pharmacy if they offer this special arrangement or call our Customer Service Department at the phone number on your ID card for a list of retail pharmacies that offer the mail service pharmacy level of benefits.

*If an FDA approved generic drug is available for a brand name drug, but you or your physician choose the higher price brand name drug, then you are responsible for the brand name drug plus the difference in cost between the brand name drug and the generic drug.

**THIS IS NOT A CONTRACT**

It is an overview of your benefits. For more detailed information, please contact your benefits administrator or ask us for a copy of the Certificate of Coverage for this health plan. If there are discrepancies between this benefit overview and the Certificate of Coverage, the Certificate will govern.
Your Prescription Drug Coverage

Tier 1 (lowest level copayment)...for generic prescriptions – Your prescription cost share will usually be lowest when you purchase a generic drug.

Tier 2 (mid-level copayment)...for brand-name medications on the Anthem Formulary – Your copayment is higher than for drugs on Tier 1, but less than for brand name medications not on the Anthem Formulary (Tier 3).

Tier 3 (highest level copayment)...for medications not included on the Anthem Formulary – You have coverage for non-formulary brand-name prescription drugs, but your out-of-pocket costs will be higher than for generic medications and brand-name drugs on the formulary.

If an FDA-approved generic drug is available for a brand name drug, but you or your physician choose the higher priced brand name medication, you are responsible for the brand-name copayment plus the difference in cost between the brand name drug and the generic.

About the Anthem Formulary

One way we contribute to the overall quality of your health coverage is by maintaining a drug formulary. Your doctor may choose your prescriptions from this list, which is created and managed by a committee of practicing physicians and pharmacists. The committee meets periodically to review and update the formulary based on findings in pharmaceutical research and the medical community. You and your doctor can search the Anthem Formulary at anthem.com.

An Extensive Network of Pharmacies

As part of your prescription drug benefits, you’ll have access to more than 50,000 chain and independent pharmacies across the country.

Save a trip to the pharmacy – The Anthem Rx Direct Mail Service

If you choose, you may purchase your prescription drugs through Anthem Rx Direct. Prescriptions are filled promptly, checked for safety and accuracy by registered pharmacists, and delivered to your home in confidential, secure packaging. Depending on your drug benefits and the particular medication prescribed by the doctor, you may be able to order up to a 90-day supply of your medication. You’ll be able to order refills by toll-free telephone or at anthem.com.

Check Out the Drug Interaction Checker

By searching the Anthem Formulary at anthem.com, you’ll also be able to check your medication for interactions with other prescription drugs, over-the-counter medications, herbal supplements and even foods.
Get The Most From Your Health Benefits

Anthem Rewards℠ – Be active. Be healthy. Be rewarded.

Walk, play ball, go skiing, mow the lawn. For everyday that you’re physically active for at least 30 minutes – and track your activity online – you earn 10 points. Once you have 250 points, you can claim a reward for your healthy lifestyle. Or keep earning those points for even bigger and better rewards.

If you already participate in Anthem Rewards℠, keep up your healthy lifestyle and keep earning those rewards. If you haven’t signed up for the program yet, go to anthemrewards.com to see what you’re missing.

Go to anthemrewards.com for a full list of rewards, menu planners, nutrition logs, weight trackers and many more online tools to support an active lifestyle.

24-Hour Nurse Line

Do you wish you had free, 24-hour access to a health professional to help you understand a medical problem? You do, when you become an Anthem Blue Cross and Blue Shield member.

You and your covered dependents can call Nurse Line from anywhere in the U.S. and Canada. An experienced nurse/clinician will help you:

• Research available options for the care you may need
• Mail you free information about health-related topics
• Provide information to help you communicate more effectively with your doctor

The toll-free number will be part of your member materials, sent after you enroll.

This program is meant to complement the services of your doctor, not replace a visit to a medical office. And while a call to the Nurse Line may be helpful at 2 a.m. when you have a 100 degree fever, it's NOT meant to be used in more serious situations. If your situation is critical or life threatening, call 9-1-1, or go to the nearest emergency room.

Discounts on health products and services

As an Anthem Blue Cross and Blue Shield member, you’ll have access to SpecialOffers@Anthem℠, a program of special discounts on health-related products and services that can help you stay healthy and fit.

• Laser vision correction
• Contact lenses
• Fitness clubs and home gym equipment
• Allergy and asthma relief products
• Weight loss programs
• Vitamins and mineral supplements
Get The Most From Your Health Benefits (continued)

- Bicycle and inline skating helmets
- Baby care accessories and safety products
- Pedometers, heart rate and blood pressure monitors
- Wellness books
- Massage therapy
- Appalachian Mountain Club memberships
- Hearing aids and hearing products
- Medical ID bracelets and pill box timers/reminders
- Eldercare services and personal emergency response systems
- Over-the-counter health and beauty products

For a full listing of SpecialOffers@AnthemSM, visit anthem.com.

Anthem Healthy SolutionsSM

Our mission is to improve the health of the people we serve. That's an important reason for Anthem Healthy SolutionsSM, our portfolio of programs promoting health education, prevention, detection and management. Offerings include:

- Education initiatives for people with chronic conditions such as:
  - Asthma
  - Cardiovascular disease
  - Depression
  - Diabetes
  - Hypertension
  - Obesity
- Women’s health and education programs
- Immunization and important health reminder programs
- Preventive care benefits
- Proactive Care Management (for members coping with serious illness, injury or a chronic condition)

All Anthem Healthy SolutionsSM programs are voluntary, completely confidential and available to eligible members. For more information on our programs, go to anthem.com and click on your state.
**anthem.com – Online tools to help track your health benefits 24/7**

*MyAnthemSM* – available through *anthem.com* – is your personalized portal to the world of health and benefit information. You’ll especially appreciate being able to take advantage of the online member services like:

- Searching the Online Provider Directory for network physicians
- Viewing coverage and benefit information
- Examining current and past claims
- Changing primary care physicians (if applicable)
- Requesting new ID cards
- Changing passwords
- Checking eligibility information for you and covered dependents
- Updating your e-mail address
- Asking questions about your benefits

*Health Decision Support Tools* – *Subimo Healthcare Advisor™* provides access to performance data about specific hospitals, as well as guidance on treatment options. If you have prescription benefits through Anthem Blue Cross and Blue Shield, *Subimo PharmaAdvisor™* will help you get easy-to-understand information about more than 11,000 drugs, including medication comparisons, side effects and interactions. *Subimo Coverage Advisor™* helps you understand what health care services you might need and provides an estimate of the related costs.

*LifeAfter50* – This Web site, accessible through *anthem.com*, provides online information and tools tailored to the unique health and wellness needs of baby boomers and seniors.

*It’s all just a click away!*

*MyHealth@Anthem®,* the health information section of *anthem.com*, lets you:

- Search health and wellness articles
- View daily health news of interest to you
- Sign up for personalized weekly electronic newsletters
- View condition-specific self-care centers (for asthma, diabetes, heart disease, hypertension, weight control, etc.)
- Look up detailed nutrition information on 30,000 foods
- Participate in health assessments and interactive polls
- Keep a daily health diary

**Take Your Virtual Tour**

Visit our Web site to experience the electronic tools we offer (*anthem.com* > Members > Select your state).
Using Your Benefits

Here are some helpful tips and guidelines to help you get the most from your benefits, as well as your overall health care experience.

Know your benefits before receiving care.
And be ready to pay any copayment or coinsurance at the time you receive treatment.

Be sure to show the office staff your member ID card(s) when seeking care.
Your member ID card contains important information that the medical office staff will need to submit claims on your behalf.

Use network physicians, hospitals and other health care professionals.
Because network providers accept our negotiated rates, you’ll have lower out-of-pocket expenses. And most physicians’ offices will submit claims on your behalf, saving you the hassle of paperwork. You can search for network providers at anthem.com.

Use emergency services appropriately.
The emergency room is meant for an injury or illness that, in the judgement of a reasonable person, requires immediate treatment to avoid jeopardizing life or overall health.

Notify your employer of any change of address or coverage status.
This will help us to forward important benefit information to you, when necessary.

Let us know about new family additions.
If your family grows due to a birth, adoption or marriage, be sure to enroll your new daughter, son or spouse within 31 days. Contact your benefit office at work to request a change form, or go online to anthem.com.

Let your children away at college know how to access covered benefits.
If your covered dependent children attend college out of state, they can still receive benefits through your health plan for urgent and emergency situations. (Additional benefits may also be available to them while away at school, depending on the type of health plan you have.)
Take advantage of discounts on health products and services.

The SpecialOffers@Anthem feature of your plan provides you access to a number of discounts on health products and services, like laser correction surgery; fitness club memberships; hearing aids; allergy relief products; and many more. Go to anthem.com for a full list.

Get answers to your questions – toll-free or online.

Our goal is to make your health plan materials as simple and easy-to-understand as possible. But for those times when you need further explanation or have additional questions, just call the toll-free customer service number printed on your member ID card (sent to you after you enroll). Our dedicated service representatives are available with prompt, accurate answers during normal business hours. You can also get many questions answered at the online member service section of anthem.com.

Enjoy peace of mind carrying health care’s most recognized symbols.

Anthem Blue Cross and Blue Shield has been serving the people of this state for more than 60 years. No other insurer can match that stability...that commitment...that experience.
Protecting Your Privacy

The privacy procedures in place at Anthem Blue Cross and Blue Shield are guided by one simple principle: a person’s state of health is his or her personal business.

How We Protect Your Privacy

Anthem Blue Cross and Blue Shield, and its affiliates and subcontractors, are committed to protecting the privacy of our members. We have specific policies that address the way health care information and other personal information is collected, used and disclosed.

Anthem Blue Cross and Blue Shield receives information that is necessary to determine health benefits from our members and from their health care providers. In addition, personal information may be collected from sources other than the insurance consumer or consumers seeking coverage, such as other insurers. This information is received by mail, in person, by telephone and electronically. It is protected by our secure buildings, secure electronic systems, and by Anthem Blue Cross and Blue Shield associates’ written commitment to the terms and conditions of our confidentiality policy. Health care and personal records are accessed only by associates whose specific jobs require them to do so. Health care and other personal information is not disclosed to or exchanged with third parties without authorization, unless its disclosure or exchange is necessary to determine benefits, comply with legal or regulatory requirements, or to permit Anthem Blue Cross and Blue Shield or Anthem Blue Cross and Blue Shield consultants to perform routine business activities. Compilations of data and statistical analyses that do not disclose or lead to the disclosure of member identity may be released to health data organizations, public health organizations, or employers without violating Anthem Blue Cross and Blue Shield legal and ethical obligations of confidentiality.

For all other types of disclosures, Anthem Blue Cross and Blue Shield requires the party requesting disclosure of the information to obtain specific written consent from the member.

Your Right to Access and/or Supplement Personal Information

Upon written request, properly identifying the member, Anthem Blue Cross and Blue Shield will permit a member or a member’s authorized representative to see and copy, or obtain a copy of, any recorded personal information about that member held by Anthem Blue Cross and Blue Shield that is reasonably described and can be locatable and retrievable, within 30 days of the request. A written request may also be submitted to correct, amend, or delete any recorded personal information about that member held by Anthem Blue Cross and Blue Shield, and we will respond within 30 days of the request. Anthem Blue Cross and Blue Shield shall notify the member that it will comply with the request or notify the member that it will not comply, but will accept a statement regarding what the member thinks is the correct, relevant or fair information or why the member disagrees with Anthem Blue Cross and Blue Shield’ refusal to correct, amend or delete recorded personal information from the member, and will notify others of the filing of such a statement as required by law.
Protecting Your Privacy (continued)

**Contracted Providers**

All contracted providers are required to maintain appropriate policies and procedures to safeguard and hold confidential members’ health care or personal information. Anthem Blue Cross and Blue Shield’s written agreements with health care providers and consultants require them to maintain the privacy of our members.

**Additional Information**

This notice serves as an abbreviated description of our confidentiality policy. For a more complete notice of our policy, please call the number on the back of your health plan ID card, or contact our customer service representatives at (800) 482-0966.
Your Rights and Responsibilities

We are committed to:

• Recognizing and respecting you as a member.
• Encouraging your open discussions with your health care professionals and providers.
• Providing information to help you become an informed health care consumer.
• Providing access to health benefits and our network providers.
• Sharing our expectations of you as a member.

You have the right to:

• Receive covered services from your primary care provider in a timely manner.
• Participate with your health care professionals and providers in making decisions about your health care.
• Select a participating primary care physician if required by your health benefit plan, and change your selection at any time.
• Receive the benefits for which you have coverage.
• Be treated with respect and dignity.
• Privacy of your personal health information, consistent with state and federal laws, and our policies.
• Receive information about our organization and services, our network of health care professionals and providers, and your rights and responsibilities.
• Discuss with your physicians and providers appropriate or medically necessary care for your condition, regardless of cost or benefit coverage.
• Make recommendations regarding the organization’s members’ rights and responsibilities policies.
• Voice complaints or appeals about:
  • Our organization,
  • Any benefit or coverage decisions we (or our designated administrators) make,
  • Your coverage, or
  • Care provided.
• For assistance at any time, contact your local insurance department:
  Phone: (800) 300-5000
  Write: Bureau of Insurance Department of Professional and Financial Regulation
  #34 State House Station
  Augusta, ME  04333-0034
You have the responsibility to:

• Choose a primary care physician if required by your health benefit plan.

• Understand your health problems and participate, along with your health care professionals and providers in developing mutually agreed upon treatment goals to the degree possible.

• Provide, to the extent possible, information that we and/or your health care professionals and providers need.

• Follow the plans and instructions for care that you have agreed on with your health care professional and provider.

• Tell your health care professional and provider if you do not understand your treatment plan or what is expected of you.

• Refuse treatment and be informed by your health care professional and provider about the consequences of your refusal.

• Know how and when to access care in routine, urgent and emergency situations.

• Follow all health benefit plan guidelines, provisions, policies and procedures.

• Let our Customer Service Department know if you have any changes to your name, address, or family members covered under your policy.

• Provide us with accurate and complete information needed to administer your health benefit plan, including other health benefit coverage and other insurance benefits you may have in addition to your coverage with us.

We are committed to providing quality benefits and customer service to our members. Benefits and coverage for services provided under the benefit program are governed by the Subscriber Agreement and not by this Member Rights and Responsibilities statement.
Your Special Enrollment Rights

This notice explains when you and your dependents not covered by Anthem have the right to enroll on a special basis.

If you choose not to enroll in an Anthem health plan, there are special times when you and your eligible dependents can do so.

If you decline to enroll yourself or your dependents (including your spouse) because you have other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan at a later time. This would occur if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents’ other health coverage). However, you must request enrollment within 31 days after your or your dependents’ other coverage ends (or after the employer stops contributing toward the other coverage).

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

Examples

Example 1 – Loss of other coverage: You and your family are enrolled through your spouse’s coverage at work. Your spouse’s employer stops paying for coverage. In this case, you and your spouse, as well as other dependents on your policy, may be eligible to enroll in one of our health plans.

Example 2 – You have a new dependent: You get married. You and your spouse and any other new dependents may be eligible to enroll in the plan.

You have 31 days to enroll

In each case, you may apply for enrollment with us within 31 days after:

- The other coverage ends.
- The employer stops contributing toward the other coverage.
- The marriage, birth, adoption or placement for adoption.

To request a special enrollment or obtain more information, contact Customer Service at (207) 822-7272 or (800) 482-0966.
An employer may elect to insure or self-fund its group health plan(s). For self-funded accounts, Anthem Blue Cross and Blue Shield provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims. Please consult your employer for plan funding details.

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