Anthem BlueCross BlueShield

Individual and Family Health Care Plans
for Indiana

Our plans fit your plans

SmartSense® Plus

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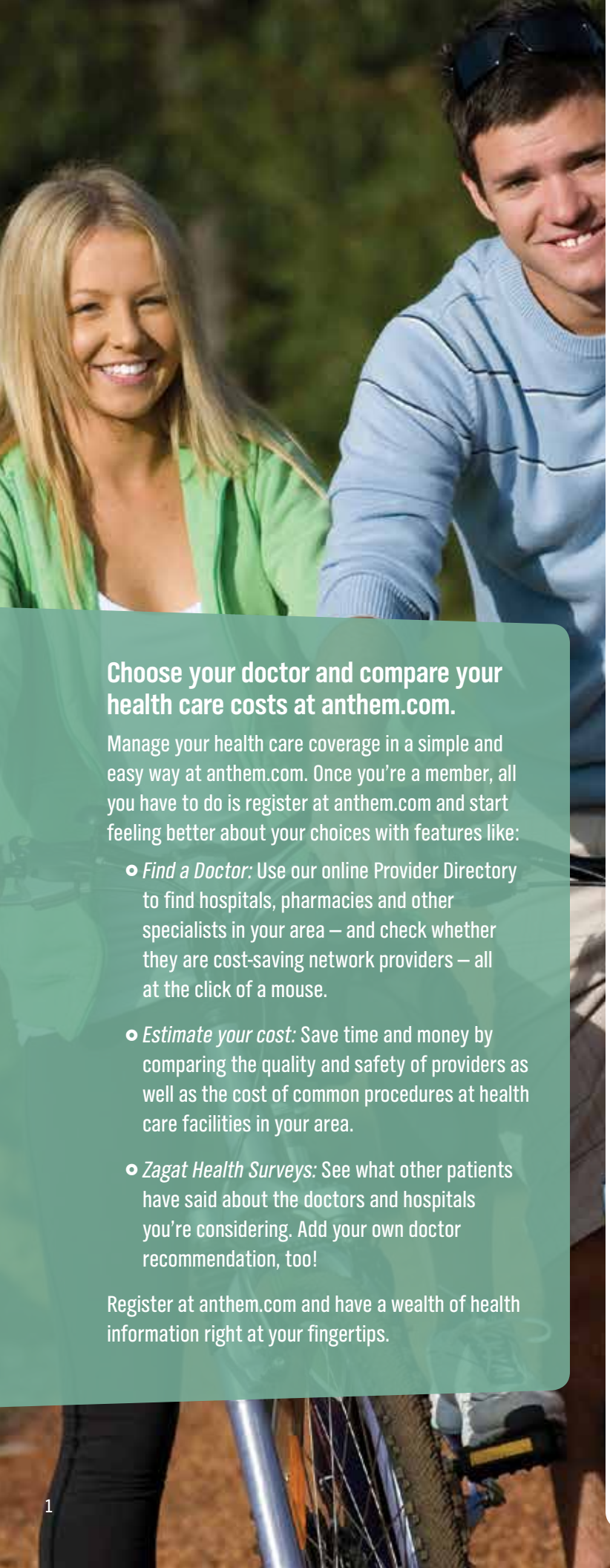


Choose your doctor and compare your health care costs at anthem.com.

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.

Our plans fit the way you live.

In an ever-changing world, 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.

For over 65 years, Anthem Blue Cross and Blue Shield has provided health care coverage and security to our Indiana neighbors. And now, we're pleased to offer these same Individual health care plans with added benefits and features from the Affordable Care Act.

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 choices as unique as you are. And if you have any questions, we're here to help.

Experience you can count on

Our goal is to help make your life easier by improving your health and the health care experience. That's why we offer:

- *One of the largest provider networks in Indiana.* With more than 14,000 doctors and specialists and nearly 140 hospitals throughout the state,* chances are your doctor is in one of our networks.
- *A choice of plans to help fit your budget and lifestyle.* No matter where you are in life, we've got a plan designed to help fit your health coverage needs, as well as your budget.
- *Optional dental and life insurance.* To help improve your health even more, we also offer dental and term life coverage, and make it easy to sign up.
- *Coverage that travels with you.* No matter where life takes you, your health coverage goes with you. And the Blue Cross and Blue Shield Association's Blue Card® program makes it easy to access providers throughout the country.
- *ConditionCare for one-on-one help* from professionals trained in managing chronic conditions like asthma, diabetes, coronary artery disease, chronic obstructive pulmonary disease and heart failure.
- *Future Moms*, a program designed to help you have a healthy pregnancy. While not maternity coverage, Future Moms provides educational materials, certain screenings and 24/7 phone access to registered nurses.

*BCBSA Provider Data Counts, 2011.

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 lower the overall cost of covered medical services, including your share of those costs.

This is true whether you are paying the whole cost for covered services (such as while you are meeting your deductible), or whether we are sharing the cost. With over 14,000 doctors and specialists and nearly 140 hospitals,* chances are your provider already takes part. Just visit a network provider to take advantage of the savings.

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

Cost Sharing: The costs of health 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 costs, 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 (annually) 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. Most often, 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. 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 network covered services. Once you reach this maximum, the plan pays at 100% for most covered services for the rest of the calendar year.

Prescription Drugs are medications that must be approved for use by your doctor. We offer 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 made and distributed by many companies, so their cost can be much lower. Generic drugs must, by law, contain the same active ingredients as their brand-name version and have the same benefit.

Brand-name Drugs are prescription drugs that are made and marketed under a registered name. Most often, they are patented and may only be offered by certain manufacturers.

Tiers represent a cost level within the generic and brand-name prescription drug categories. The prescription drug coverage under your health care plan will differ for each of these tiers. Not all products have this tiering.

- **Tier 1:** These drugs generally include generic drugs and a few lower-cost brand-name drugs.
- **Tier 2:** These drugs generally include higher-cost generic and brand-name drugs.
- **Tier 3 and 4:** These drugs include the highest-cost brand-name drugs.

Formulary is a list of prescription drugs our health care plans cover. They include generic and preferred brand-name drugs that have been rigorously reviewed and selected by a committee of practicing doctors and clinical pharmacists for their quality and how well they work. 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. Formulary lists can be found at anthem.com.

Health Savings Account (HSA) is a special bank account that can be set up by members 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 adviser.

*BCBSA Provider Data Counts, 2011.

SmartSense® Plus

Is this the right plan for you?

SmartSense Plus was designed to offer affordable, solid protection without a lot of bells and whistles that may not be important to you.

Prescription drug coverage

SmartSense Plus includes coverage for generic and select brand-name drugs.

For an additional cost, you can upgrade the SmartSense Plus prescription benefit to get more coverage for more brand-name drugs. There is a separate deductible for the brand-name drugs when you choose the prescription drug upgrade.

See your Benefit Guide for more details.

How to customize your SmartSense Plus plan

With SmartSense Plus, you have some choice and flexibility to change the plan to better meet your needs. SmartSense Plus offers a choice of:

Deductible: You can often lower your premium by choosing a higher deductible. Simply choose the deductible and premium combination that works best for you.

Coinsurance: You get a choice of coinsurance levels, depending on the deductible you choose, allowing you to vary your level of cost sharing – and you can lower your premium when you choose a higher coinsurance level.

Prescription drug benefit: You can customize your plan by selecting the optional prescription drug upgrade coverage, as described above.

Other optional coverage: You add more protection for you and your family by purchasing optional dental or life insurance. See your Benefit Guide and the dental and life information in the back of this brochure for more details.

SmartSense Plus plan highlights

SmartSense Plus offers affordable price options, solid protection that covers essentials, and even some immediate benefits before the deductible kicks in.

Features:

- You get immediate coverage, with predictable copayments for the first three doctors' office visits, per plan member, each calendar year.
- You have preventive care benefits that help you focus on staying healthy.
- You have a choice of prescription drug coverage options.

You should know:

- Maternity benefits are not available with this plan.
- After the first three doctor visits, all other visits apply to your deductible.
- Generic and select brand-name drugs are also available before the deductible, with a copayment or coinsurance.

Anthem BlueCross BlueShield

Benefit Guide for Indiana

Benefits		*SmartSense® Plus*										
Calendar-year Deductible		Your choices:										
Individual	Network:	$500	$500	$1,000	$1,000	$1,500	$1,500	$2,500	$2,500	$3,500	$5,000	$10,000
	Non-network:	$500	$500	$1,000	$1,000	$1,500	$1,500	$2,500	$2,500	$3,500	$5,000	$10,000
Family	Network:	$1,000	$1,000	$2,000	$2,000	$3,000	$3,000	$5,000	$5,000	$7,000	$10,000	$20,000
	Non-network:	$1,000	$1,000	$2,000	$2,000	$3,000	$3,000	$5,000	$5,000	$7,000	$10,000	$20,000
Network coinsurance options		30%	50%	30%	50%	30%	50%	30%	50%	30%	30%	30%
Calendar-year Out-of-pocket Maximum		Add your chosen deductible to the amount below										
Individual	Network:	$3,500	$3,500	$3,500	$3,500	$3,500	$3,500	$3,500	$3,500	$3,500	$3,500	$3,500
	Non-network:	$7,500	$7,500	$7,500	$7,500	$7,500	$7,500	$7,500	$7,500	$7,500	$7,500	$7,500
Family	Network:	$7,000	$7,000	$7,000	$7,000	$7,000	$7,000	$7,000	$7,000	$7,000	$7,000	$7,000
	Non-network:	$15,000	$15,000	$15,000	$15,000	$15,000	$15,000	$15,000	$15,000	$15,000	$15,000	$15,000
How family deductibles and family out-of-pocket maximums work		Each family member has an individual deductible and out-of-pocket maximum. The family deductible and out-of-pocket maximum can be satisfied by 2 or more members. No one person can contribute more than their individual deductible or out-of-pocket maximum.										
Plan lifetime maximum		None										

Covered Services	Your share of costs (after deductible, unless waived or not subject to deductible)
Doctor office visits	Network: • Office visit copayment for first 3 visits: $35 copayment, deductible waived, for first 3 visits per person per calendar year for primary care physician/specialist. Other office services are subject to deductible and coinsurance. • Office visit coinsurance for 4+ visits and other services: 30% or 50% coinsurance* Non-network: 50% or 70% coinsurance*
Professional and diagnostic services (X-ray, lab, anesthesia, surgeon, etc.)	Network: 30% or 50% coinsurance* Non-network: 50% or 70% coinsurance*
Inpatient services (overnight hospital/facility stays)	Network: 30% or 50% coinsurance* Non-network: 50% or 70% coinsurance*
Outpatient services (without overnight hospital/facility stays)	Network: 30% or 50% coinsurance* Non-network: 50% or 70% coinsurance*
Emergency room services	Network: 30% or 50% coinsurance* Non-network: 30% or 50% coinsurance*
Preventive care services	Includes preventive services recommended by the United States Preventive Services Task Force, including well-child care, immunizations, PSA screenings, Pap tests, mammograms and more Network: 0% coinsurance, not subject to deductible Non-network: 50% or 70% coinsurance*
Maternity	Not covered
Optional coverage (at additional cost)	Dental, life

Prescription Drug Coverage	*SmartSense Plus*
Retail drugs (and mail-order drugs, when available)	*Standard drug coverage:* Network: • For drugs on formulary: greater of $15 copayment or 40% coinsurance • For drugs not on formulary: member is responsible for entire cost after applied Anthem negotiated discount Non-network: • For drugs on formulary: greater of $15 copayment or 40% coinsurance; member is also responsible for difference between Anthem allowable charge and actual cost of drug • For drugs not on formulary: member is responsible for entire cost
Optional drug coverage (when available)	*Upgrade drug coverage:* Separate $250 per member deductible for drugs in tiers 2, 3 and 4. Member is also responsible for the difference in allowable charge between brand and generic, plus copayment or coinsurance. Network: • **Tier 1 drugs:** retail (30-day supply): $15 copayment; mail order (90-day supply): $30 copayment • **Tiers 2, 3 and 4:** greater of $30 copayment or 40% coinsurance For **Tiers 2, 3 and 4:** $4,000 annual prescription drug out-of-pocket maximum per member Non-network: • Retail (30-day supply only): 50% coinsurance (minimum $60) per prescription. Mail order not covered.
Other covered benefits include, but are not limited to:	Ambulance, Chiropractic, Durable Medical Equipment, Home Health Care, Hospice Care, Organ Transplants, Rehabilitation Facilities, Skilled Nursing Care, Therapy Services, Urgent Care

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.

*Coinsurance is designated by the plan you choose.

NOTE: 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 toward each other.

If you need services from a non-participating provider, you may be balance billed for the difference between Anthem's Maximum Allowed Amount and the provider's actual charges. Depending on the nature of the service, the amount you owe may be significant.

Give yourself every advantage ... Good health and a bright smile.

Dental Blue® Plans

Regular dental checkups and cleanings are important to your overall health. That's why we give you the choice of adding one of these Dental Blue plans to your health coverage:

1. *Dental Blue Basic 100:* Gives you coverage for the basics, like routine checkups and fillings. If your dental needs are simple, this may be the right plan for you.
2. *Dental Blue Essential 100:* Includes coverage for the basics, plus services like crowns, bridges, root canals and dentures. If you think you may need major dental work, this is the right plan for you.
3. *Dental Blue Essential 200:* Has basically the same coverage as Essential 100, but this plan also gives you wider choice of network dentists for a slightly higher cost. If your favorite dentist is in our larger network, this plan may be the best choice for you.

How dental networks help you save

While all three Dental Blue plans let you go to any dentist, you'll save the most money when you choose a dentist from your plan's network. There are two Dental Blue networks:

- *Dental Blue 100 network:* This is the value network for our Dental Blue 100 plans. Dental Blue Basic 100 and Essential 100 members can save the most on dental care when they choose a dentist from this network.
- *Dental Blue 200 network:* Includes all of the 100 network, plus even more choices of dentists and specialists. Dental Blue Essential 200 members can save the most on dental care when they choose a dentist from this network.

How to choose the dental plan that works best for you.

Use the chart below to compare dental plan benefits side by side.

Plan Names	*Dental Blue Basic 100*	*Dental Blue Essential 100*	*Dental Blue Essential 200*	*All Plans**
Networks	Dental Blue 100	Dental Blue 100	Dental Blue 200 (includes all Dental Blue 100 dentists)	Benefit from negotiated rates at Dental Blue providers.
Preventive and diagnostic care	100% covered within plan network; includes routine checkups, X-rays and fluoride applications for children	100% covered within plan network; includes Basic 100 services plus space maintainers		No waiting period; no deductible in or out of network; covers two routine cleanings and oral exams per year; molar/bicuspid X-rays; full-mouth X-rays covered once every five years
Minor restorative dental care	80% covered within plan network and pays set amount out-of-network after $50 deductible;* includes fillings and space maintainers; extractions not covered	Pays set amount within plan network and out-of-network after $50 deductible;* includes fillings and extractions; space maintainers considered preventive/diagnostic care		No waiting period
Major restorative dental care	Not covered	Pays set amount within plan network and out-of-network after $50 deductible;* includes crowns, bridges, root canals and dentures		12-month waiting period with Dental Blue Essential plan options

*Per member, per calendar year
This is only a summary of Dental Blue benefits. For complete benefit details, please refer to your Individual Dental Contract.

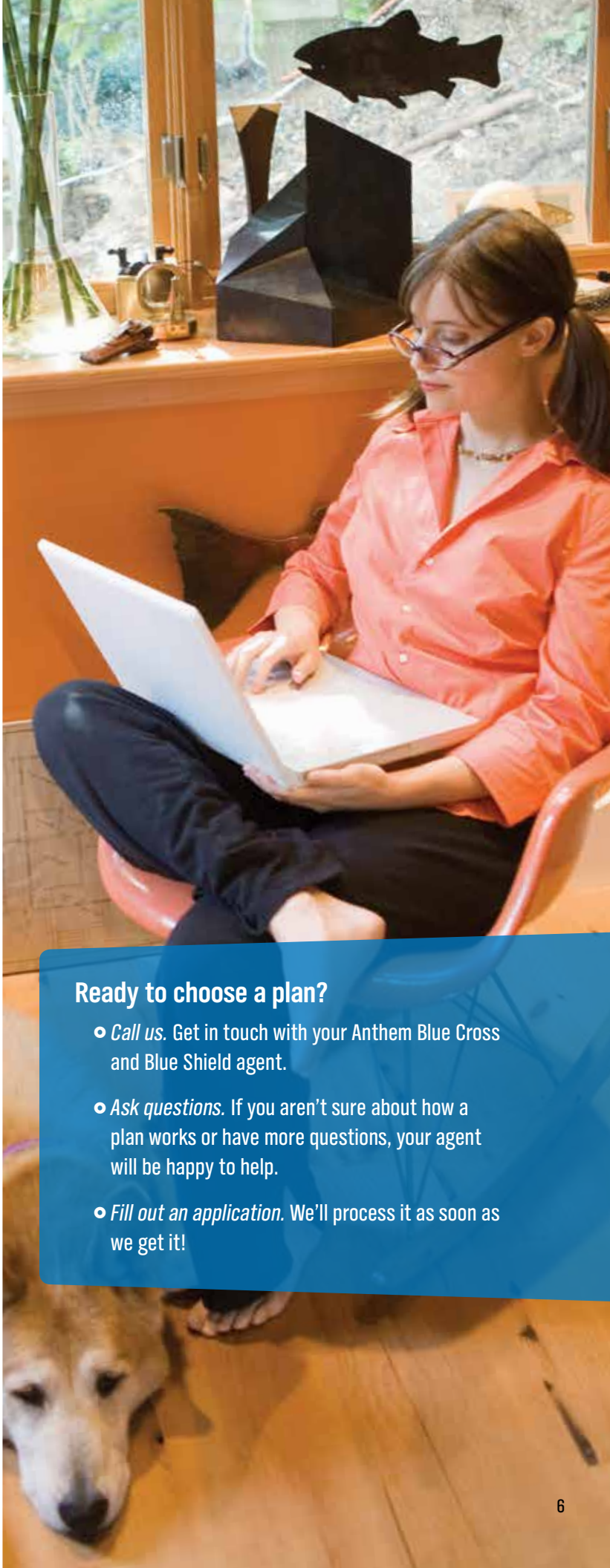
Optional Term Life Insurance

You can add Anthem Blue Preferred® Term Life Insurance to your health coverage. It's easy. There are no medical exams or extra forms to fill out. Simply use your application to apply for coverage.

Term Life Monthly Rates			
Age	**$15,000**	**$25,000**	**$50,000**
1-18	$1.50	$2.50	N/A
19-29	$2.85	$4.75	$9.50
30-39	$3.30	$5.50	$11
40-49	$7.50	$12.50	$25
50-59	$20.85	$34.75	$69.50
60-64	$29.40	$49	$98

Save time

Hate writing checks? After your first 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?

- *Call us.* Get in touch with your Anthem Blue Cross and Blue Shield agent.
- *Ask questions.* If you aren't sure about how a plan works or have more questions, your agent will be happy to help.
- *Fill out an application.* We'll process it as soon as we get it!

Anthem BlueCross BlueShield

Individual and family 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 more 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 brochure from your computer, it should be at the end. If you did not get a copy of the Coverage Details, be sure to get in touch with your Anthem agent.

This brochure is intended as a brief summary of benefits and services; it is not your Contract/Certificate of Coverage. If there is any difference between this brochure and your Contract/Certificate of Coverage, the provisions of the Contract/Certificate of Coverage 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.

We want you to be satisfied.

If you aren't satisfied with your coverage, you can cancel it within 30 days after you receive your Contract or Certificate of Coverage or have access to it online, whichever is earlier. If you haven't submitted any claims, you'll get a full refund of the premium you paid when coverage is cancelled within the first 30 days. You can view your Contract or Certificate of Coverage online or receive a paper copy of it upon request as outlined in your initial membership letter.

Ready to enroll?

Call your Anthem agent today!

Please visit healthcare.gov to view a Summary of Benefits and Coverage.

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Indiana Coverage Details

Things you need to know before you buy...

Anthem BlueCross BlueShield

SmartSense® Plus, Premier Plus, CoreShare℠ and Lumenos® HSA Plus

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

Who Can Apply?

You can apply for coverage for yourself or with your family. You must be a resident of Indiana, under the age of 65, not eligible for Medicare and a legal resident of the U.S. Family health coverage includes you, your spouse or domestic partner and any dependent children. Children are covered to the end of the month in which they turn age 26. An eligible dependent may be your children, your spouse or domestic partner's children or a child subject to legal guardianship. In addition, other** eligible dependents, including your grandchildren or other blood relative, who depend on you for 50% of their financial support, can also be covered under this coverage.

**Requires submission of completed Affidavit of Dependency for Indiana Individual Policies.

What's A Pre-Existing Condition?

For applicants age nineteen (19) and older, our plans cover preexisting conditions after you've been enrolled in the plan for 12 months. A pre-existing condition is any medical or physical condition you had in the 12 months right before you enrolled. If you received medical advice, a diagnosis, care or treatment for the condition — or if it was recommended that you do so — that qualifies it as "pre-existing". The pre-existing condition limitation does not apply to applicants under age nineteen (19).

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 12-month waiting period. Anthem Blue Cross and Blue Shield will credit the time you were enrolled on the previous plan.

Access to the MIB

Information regarding your insurability will be treated as confidential. Anthem Blue Cross and Blue Shield or its reinsurers may, however, make a brief report thereon to the 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.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If 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.

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. Anthem Blue Cross and Blue Shield, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

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
- 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.

Anthem BlueCross BlueShield

Utilization Management and Case Management

(continued) 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.

Our Appeal Rights And Confidentiality Policy

If we deny a claim or request for benefits completely or partially, we will notify you in writing. The notice will explain why we denied the claim/request and describe the appeals process. You can appeal decisions that deny or reduce benefits. We encourage you to file appeals right away, when you first get an initial decision from us, but we require that you file within six months of getting one. You should send additional information that supports your appeal and state all the reasons why you feel the appeal request should be granted. We will review your appeal and let you know our decision in writing within 30 days of receiving your first appeal. If you are denied coverage based on medical necessity or experimental/ investigative exclusions, you can request that a board-eligible or board-certified specialist review your appeal. If we deny coverage for reasons other than medical necessity or experimental/ investigative reasons, you can also appeal.

Please call customer service or check your Contract or Certificate of Coverage for more information on our internal appeal and external review processes. Unless our notice of decision includes a different address, send requests for a review of appeal to:

Anthem Blue Cross and Blue Shield
Appeals Coordinator
P.O. Box 105568
Atlanta, GA 30348-5568

If we uphold our decision throughout the appeals process, you can request a review by the Indiana Department of Insurance. In addition to the appeals processes we just described, Anthem has adopted a confidentiality policy in Indiana. This policy includes guidelines regarding the protection of confidential member information and a member's right to access and change information in Anthem's possession. The policy clearly points out when a member needs to sign a release before Anthem can disclose information to a member's provider, spouse or other family members.

We Want You To Be Satisfied

If you aren't satisfied with your coverage, you can cancel it within 30 days after you receive your Contract or Certificate of Coverage or have access to it online, whichever is earlier. If you haven't submitted any claims, you'll get a full refund of the premium you paid when coverage is cancelled within the first 30 days.

You can view your Contract or Certificate of Coverage online or receive a paper copy of it upon request as outlined in your initial membership letter. This document is not a part of the Contract or Certificate of Coverage. If you are approved for coverage, the Contract or Certificate of Coverage you receive will include all the details of your plan. In the event of a conflict between the information in this document and your Contract or Certificate of Coverage, the terms of your Contract or Certificate of Coverage will prevail. Read your Contract or Certificate of Coverage carefully. Anthem has the right to rescind, cancel, terminate or reform your coverage based on provisions described in the Contract or Certificate of Coverage.

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.

Selecting health coverage is an important decision.

To assist you, we supply the following for the plans under consideration: Brochure, Benefit Guide, Coverage Details and Enrollment Application. If you did not receive one or more of these materials, please contact your Anthem Blue Cross and Blue Shield agent to request them.

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