Individual and family health benefit plans for Missouri

We make it easy. Find out how.

Bronze, Silver and Gold plans

Plans certified by the Health Insurance Marketplace

03261MOMENABS Rev. 9/13

Health care may never be simple, but choosing the right plan can be.

When it comes to Individual health care coverage, it's not one-size-fits-all. With Anthem Blue Cross and Blue Shield (Anthem), you get a wide range of options so you can compare plans and find the best coverage for your needs and budget. No one knows what you and your family need better than you. Just let us know and we're here to help when and where you need us.

To learn more about your options, review this information with your Anthem authorized representative.

Total health care

We offer you a total health solution, so you can live healthier, feel better and save money doing it. With Anthem, you get:

- Easy-to-use tools to find a doctor, hospital, provider or pharmacy
- No-cost preventive care, like checkups and flu shots
- 24/7 NurseLine
- Online support to manage your plan
- Reliable customer service

Get help today!

Call your Anthem authorized representative or visit us online at anthem.com where you can view and compare plan options.

Network value

Access to the best doctors in your area is important. And we've created our network of doctors and hospitals with this in mind. Our goal is to work with doctors and hospitals who will offer the best care possible — at a lower cost. Our Pathway X network includes:

- Doctors and hospitals
- Lab, durable medical equipment and behavioral health providers
- Urgent and emergency providers

A friendly face in a changing world

Health care is changing, but one thing is clear: we're here to provide health care benefits to people like you — now and in the future. Starting in 2014, all Americans must have health coverage. In fact, you can't be turned down! You can purchase coverage direct from Anthem or through your state's health insurance marketplace (also known as the Exchange). In some cases, the government may even help pay for your coverage. Get the health care coverage you need from Anthem.

How Health Care Coverage Works

Health care coverage can help protect you against the high costs of care. With most health care coverage, you pay a monthly fee called a premium, then you share some of the cost of covered care with the company that provides your coverage. With Anthem, you can choose the level of cost sharing that works best for your health care needs and budget.

Here's an example: *Meet John*

John's story is only an example of how health plans work. Be sure to look at the benefits for each of our plan choices for specific information.

John's health plan has the following benefits:

- $35 copay for doctor visits.
- $2,000 deductible.
- 30% coinsurance.
- $5,000 out-of-pocket limit.

After injuring his knee in a soccer game, John calls his doctor. He chooses providers in our network, which saves him the most money. By choosing in-network providers, John gets lower negotiated rates (meaning, discounted prices). In the following examples, you'll see what John paid and why it's important to have health insurance.

Copay (Copayment)

On some plans you pay a fixed dollar amount for certain services when you get them. For example, when you see a doctor, you may be asked to pay a $35 copay.

Let's take a closer look at John's doctor's visit copay:

- *Doctor visit cost (without insurance):* $200
- *Anthem's negotiated rate:* $140
- *Anthem pays:* $105
- *What John paid:* $35 (his plan's copay for doctor office visit)

Deductible

You pay this amount for covered medical services each calendar year (January through December). Covered services that apply to the deductible may include lab work, X-rays, anesthesia and surgeon fees. (Covered preventive services start before the deductible is met.) Your deductible starts over each calendar year.

Please note:

For non-HSA plans, each family member has an individual deductible and out-of-pocket limit. The family deductible and out-of-pocket limit can be satisfied by two or more members. No one person can contribute more than his or her individual deductible or out-of-pocket limit. For HSA qualified plans, either one or more family members must meet the family deductible before any covered services that are subject to the deductible will be paid by the plan. The family out-of-pocket limit can be met by either one or more members. Once the limit is met, no additional coinsurance will be required for the family for the remainder of the calendar year.

Here's what happens next when John's doctor orders an approved MRI of the knee and recommends surgery:

MRI

- *MRI cost (without insurance):* $1,500
- *Anthem's negotiated rate:* $1,000
- *What John paid:* $1,000 (John's payment counts toward his plan's $2,000 deductible.)

Surgery

- *Hospital/surgery costs (without insurance):* $50,000
- *Anthem's negotiated rate:* $35,000
- *What John paid:* $1,000 (John's payment satisfies the remaining $1,000 deductible.)
- *Remaining cost of surgery:* $34,000

Coinsurance

Once you've met your deductible, Anthem starts paying a portion of claims. The health care bills that remain are shared between you and Anthem. Your coinsurance is the percent that you must pay for a covered service per calendar year. Having met his deductible, John's coinsurance begins.

Let's check in to see what John will be paying.

- *Coinsurance:* 30% (30% of $34,000 = $10,200)
- *What John paid:* $2,965 (John's payment satisfies the remainder of his $5,000 out-of-pocket limit.)

Out-of-pocket limit

The most you pay during a policy period before your health insurance begins to pay at 100% (of the allowed amount). The amounts you pay for your deductible, coinsurance and copay are typically what make up your out-of-pocket limit. Once you meet your out-of-pocket limit, we pay 100% (of the allowed amount) of covered services for the rest of the calendar year.

John has met his out-of-pocket and the remaining surgery costs are paid.

- *Anthem pays:* $31,035
- *Out-of-pocket limit:* $5,000

Summary

John paid far less out-of-pocket because he had health care coverage. If John had used an out-of-network provider, depending on his plan, he might not have had coverage or would have had to pay much more.

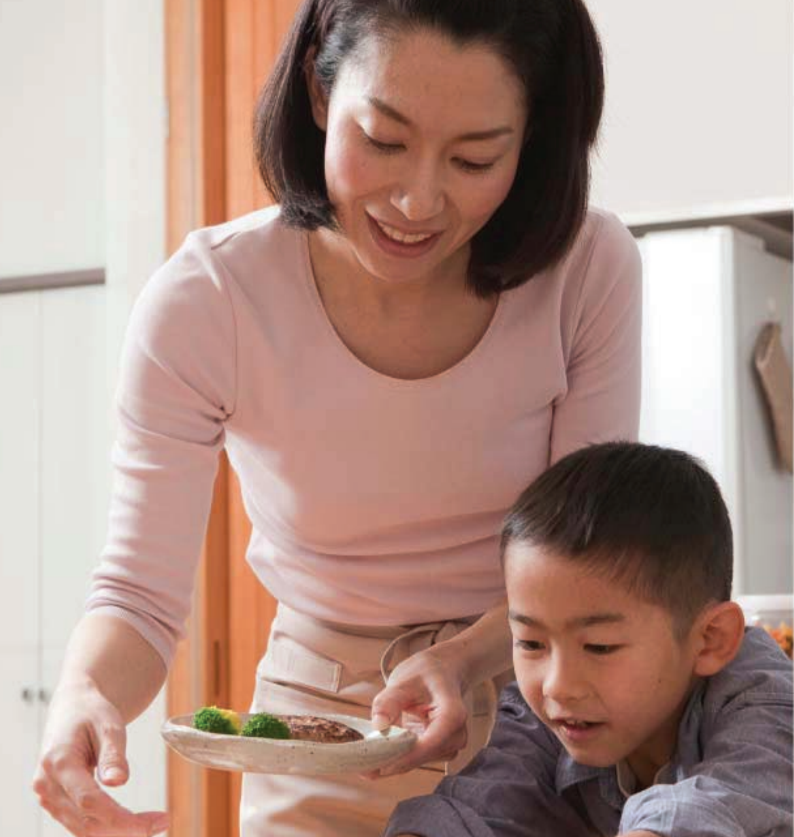
- *Total for doctor visit, X-ray and surgery (without health insurance):* $51,700
- *Total Anthem paid after discounts:* $31,140
- *Total John paid:* $5,000

Covering you A to Z

All of our plan options have one major goal in mind: Making sure you stay healthy and that you get the quality care you need when you need it. That's why, no matter which plan you choose, you're covered for preventive care to emergencies, and more!

What's covered?

- [1]Preventive and wellness services and help managing a chronic (ongoing) disease
- Outpatient (ambulatory) patient care
- Emergency services, like going to the ER or urgent care
- Inpatient care (where you stay overnight in a hospital)
- Laboratory services
- Prescription drugs
- Rehabilitative and habilitative services (habilitative services help a person learn, keep or improve skills they may not be developing normally)
- Mental health and substance abuse services
- Maternity (pregnancy) and newborn care
- Pediatric services (health care for children)



Don't forget dental and vision coverage. Check out our Anthem dental and vision plans. Just call your Anthem authorized representative or go online to anthem.com for details.

A closer look at prescription drug coverage

Prescription drug benefits help cover the cost of medications your doctor prescribes. We're here to help you better understand your prescription drug plan and the choices you have when it comes to selecting and paying for these medications.

To find out if your medication is covered, take a look at our drug list at anthem.com > Customer Support > Forms Library > Anthem Select Drug List. Covered medications are assigned to certain tiers (or levels) based on cost, availability and similar alternatives. By selecting a Tier 1 medication, you may have a lower cost share. You can usually save money by selecting a generic version of a medication. Or even save time by having medicine sent right to your home. Always talk to your doctor first about which medication is right for you.

Please visit our Find a Doctor tool on anthem.com to see if your pharmacy is in-network.

Access coverage — no matter where you are in the U.S. — with BlueCard®

When you're traveling for work or on vacation, going to the ER or urgent care is probably the last thing you want to happen. However, our plans cover emergency and urgent care in every state through the Blue Cross and Blue Shield Association's BlueCard® Program. This means you and your family have emergency and urgent care coverage from coast to coast.

Take care of yourself with no-cost preventive care

Anthem's preventive care coverage options give you access to any of our network doctors so you pay nothing out of pocket. Stay in control of your health care and your finances with $0 deductible, $0 copay and $0 cost to you for covered preventive services received in-network.

[1]Preventive and wellness services consist of services recommended by the United States Preventive Services Task Force, including well-child care, immunizations, PSA screenings, Pap tests, mammograms and more.

Your plan options

We offer plans to fit your health care coverage needs — and your budget. To make it easy to compare and choose a plan, they are split into three different levels — Bronze, Silver and Gold. Your costs and coverage increase with each level.

Bronze	With the Bronze plans, you pay less for your monthly premium but you pay more when you get care. You have broad benefits with deductibles, copays and coinsurance that may be higher than the other plans.
Silver	The Silver plans still have lower monthly premiums but you pay less when you get care. An additional cost-sharing subsidy may be available to you on this plan level.
Gold	With the Gold plan, you have richer benefits and pay less when you get care. However, the monthly premium is higher than the Bronze and Silver plans.

Make your health care dollars work harder with a Health Savings Account

A Health Savings Account (HSA) is a savings account that you can open when you have a qualified high deductible health plan (HDHP). You set up the account through a bank and fund it with post-tax dollars. That money can be used to pay for your qualified health care expenses, including prescriptions. HSA-compatible health care plans work with or without this savings account, the choice is yours.

Plan choices that are HSA-compatible include HSA in the plan name. Check with your tax advisor to see if an HSA plan is right for you and check out the insert from our preferred banking partner.

What doctors can I see?

The health care plans we offer are **DirectAccess** plans. With this type of plan, you have the freedom to see any in-network doctor you choose. It's also a good idea to have a primary care physician (PCP) for things like checkups and health issues that need ongoing care. However, you're not required to select a PCP.

What is an in-network provider?

When you need care, you will get the best value by visiting an **in-network** doctor, hospital or other health care provider. **In-network** (or participating) refers to doctors, hospitals and other health care providers that have agreed to accept lower negotiated rates (discounted prices) for their covered services. These agreed upon rates can help lower the cost of covered health care services, including your share of the costs. This is true when you are paying the whole cost for covered services (such as while you are meeting your deductible). And it's also true when we are sharing the cost (while you are meeting your out-of-pocket limit).

Out-of-network (or nonparticipating) refers to doctors, hospitals and other health care providers that are not contracted with Anthem to provide services at a negotiated rate. On some plans, you have the choice to visit an **out-of-network** doctor or hospital, but your share of the costs may be greater.

To find out if your current health care provider is in our network, visit our Find a Doctor tool on anthem.com.

Easy-to-use online tools

Anthem's website is an easy-to-use resource that allows you to manage your health care in a simple and convenient way. With our website, you can:

- Find out what is and isn't covered by your plan with an easy-to-understand breakdown of your benefits summary.
- Get instant access to your recent claims and coverage details.
- Know your costs before having certain procedures with clear estimates using our out-of-pocket cost calculator.

Get help from nurses 24/7

Anthem's 24/7 NurseLine gives you access to trained registered nurses any time of the day or night for answers to your general health questions, to help you understand your symptoms and to help you determine the right care at the right time.

Find a Doctor

Want to make sure your doctor is in our network? Need to find a new doctor or specialist? No problem! Our online Find a Doctor Tool helps you find doctors, hospitals, pharmacies and other specialists in your area — and shows whether they are cost-saving network providers. Log on to anthem.com anytime or download our mobile app right to your phone, so you can search for doctors when you're on the go.

Zagat® Health Survey

It's similar to the restaurant survey. See what other patients have said about the doctors and hospitals you're thinking about using. Add your own doctor reviews, too!

Access cost and quality information with Estimate Your Cost

Save time and money by comparing the cost of common procedures at health care facilities in your area. You'll also get to compare quality and safety.

Save time and money with an urgent care center or retail health clinic

You can save money — and usually lots of time — by going to places other than the emergency room (ER) when your condition is not an emergency. The Find a Doctor tool can help find alternatives to the ER like urgent care centers, walk-in doctor's offices and retail health clinics.

Tips for picking a health plan

Choosing the right health care coverage is an important decision. Before you choose a plan, consider these tips. And remember, your Anthem authorized representative is here to answer any questions.

- **Make sure the plan will meet your health care coverage needs**. Think about how often you see doctors and specialists. What prescription medications do you take?
- **If staying with your current doctors is important**, see if they're in our network by using our online Find a Doctor tool at anthem.com. Seeing an in-network doctor can save you a lot of money on your health care.
- **Figure out your family's budget for coverage**. Some people would prefer to pay more in premium each month and less out of pocket each time for services like doctors' visits or lab work. Plans may offer different deductible, coinsurance and copay options so you can choose the level of cost sharing that best meets your health care coverage needs and budget.
- **Consider making contributions to a Health Savings Account (HSA).** Making post-tax contributions to an HSA can help make your money go further. Talk to your financial advisor about potential tax advantages.

Can I get help paying for health insurance?

You may be able to get a tax credit or subsidy. Here are some guidelines:

- If your income is 100% to 400% of the federal poverty level, you may be able to get a tax credit that can go toward any level exchange plan (Bronze, Silver or Gold).
- If your income is up to 250% of the federal poverty level, an additional cost-sharing subsidy may be available to you. That means you may be able to get a plan with lower cost shares. Cost share subsidies are only available on Silver plans.

Do I have to buy health coverage from the Health Insurance Marketplace?

You don't have to. The Health Insurance Marketplace is just one way you can shop for health coverage. You can still get coverage directly from an insurance company. If you want to apply for a subsidy, you will have to buy coverage through the Health Insurance Marketplace.

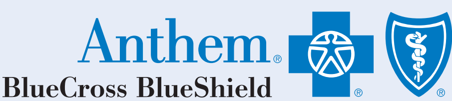
Call your Anthem authorized representative or go to anthem.com to learn more about exchanges and subsidies.

When can I purchase a plan?

Plans can be purchased once a year through an open enrollment period. This year, open enrollment is from October 1, 2013, to December 15, 2013 for a January 1, 2014 effective date. You may also enroll from December 16, 2013 through March 31, 2014 for effective dates after January 1, 2014. Check with your Anthem authorized representative for effective date options and guidelines around enrollment during other times of the year.

How do I enroll in an Anthem plan?

- If you are ready to enroll or would like more information about the health care plans offered by Anthem, call your Anthem authorized representative today!
- Visit our website at anthem.com and apply online.



Get help today!

Call your Anthem authorized representative or visit us online at anthem.com where you can view and compare plan options.

Anthem Blue Cross and Blue Shield is a Qualified Health Plan in the Health Insurance Marketplace.

We want you to be satisfied

After you enroll in a plan offered by Anthem you will receive a Contract or Certificate of Coverage that explains the exact terms and conditions of coverage, including the plan's exclusions and limitations. You will have 30 days to examine your contract's features. During that time, if you are not fully satisfied, you may cancel your contract and your premiums will be refunded, less any claims that were already paid.

This document is only a brief summary of benefits and services. Our plans have exclusions, limitations and terms under which the contract may be continued in force or discontinued. For more complete details, including what's covered and what isn't:

- See the coverage brief document included with this brochure.
- Call your Anthem authorized representative.
- Go to anthem.com.

For more information on how to access a Summary of Benefits and Coverage (SBC), please visit www.healthcare.gov and enter SBC in the search field.

A high deductible health plan is not a health savings account (HSA). An HSA is a separate arrangement between an individual and a qualified financial institution. To take advantage of tax benefits, an HSA needs to be established. This brochure provides general information only and is not intended to be a substitute for the advice of a qualified tax professional.

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Coverage Brief for Missouri Health Insurance Marketplace

Things you need to know before you buy...

Anthem Bronze DirectAccess, Anthem Bronze DirectAccess with Child Dental, Anthem Bronze DirectAccess with HSA, Anthem Silver DirectAccess, Anthem Silver DirectAccess with HSA, Anthem Gold DirectAccess, Anthem Gold DirectAccess with Child Dental, Anthem Catastrophic DirectAccess

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

Eligibility

The benefits, terms and conditions of your Contract are applicable to individuals who are determined by the Exchange to be Qualified Individuals for purposes of enrollment in a Qualified Health Plan (QHP).

Subscriber

To be eligible for membership as a subscriber on the Plan, the applicant must:

1. Be determined by the Exchange to be a Qualified Individual for enrollment in a QHP.
2. Be a United States citizen or national; or
3. Be a lawfully present non-citizen for the entire period for which coverage is sought; and
4. Be a resident of the State of Missouri and meet the following applicable residency standards;

   For a Qualified Individual age 21 and over, the applicant must:

   - Not be living in an institution;
   - Be capable of indicating intent;
   - Not be receiving optional State Supplementary Payments (SSP); and
   - Reside in the service area of the Exchange.

   For a Qualified Individual under age 21, the applicant must:

   - Not be living in an institution;
   - Not be eligible for Medicaid based on receipt of federal payments for foster care and adoption assistance under Social Security;
   - Not be emancipated;
   - Not be receiving optional State Supplementary Payments (SSP); and
   - Reside in the service area of the Exchange.
5. Agree to pay for the cost of premium that Anthem requires;
6. Reveal any coordination of benefits arrangements or other health benefit arrangements for the applicant or dependents as they become effective;
7. Not be incarcerated (except pending disposition of charges);
8. Not be entitled to or enrolled in Medicare Parts A/B and/or D;
9. Not be covered by any other group or individual health benefit plan.

For purposes of eligibility, a Qualified Individual's service area is the area in which the Qualified Individual:

1. Resides, intends to reside (including without a fixed address); or
2. Is seeking employment (whether or not currently employed); or
3. Has entered without a job commitment.

For Qualified Individuals under age 21, the service area is that of the parent or caretaker with whom the Qualified Individual resides.

For tax households with members in multiple Exchange service areas:

1. If all of the members of a tax household are not living within the same Exchange service area, any member of the tax household may enroll in a Qualified Health Plan through any of the Exchanges for which one of the tax filers meets the residency requirements.
2. If both spouses in a tax household enroll in a Qualified Health Plan through the same Exchange, a tax dependent may only enroll in a Qualified Health Plan through that Exchange, or through the Exchange that services the area in which the dependent meets a residency standard.

Dependents

To be eligible for coverage to enroll as a dependent, you must be listed on the enrollment form completed by the subscriber, meet all dependent eligibility criteria and be:

1. The subscriber's legal spouse.
2. The subscriber's domestic partner - domestic partner or domestic partnership means a person of the same or opposite sex for whom all of the following are true: he or she is the subscriber's sole domestic partner and has been for twelve (12) months or more; he or she is mentally competent; neither the subscriber nor the domestic partner is related in any way (including by adoption or blood) that would prohibit him or her from being married under state law; he or she is not married to or separated from anyone else; and he or she is financially interdependent with the subscriber.

   a. For purposes of your Contract, a domestic partner shall be treated the same as a spouse, and a domestic partner's child, adopted child, or child for whom a domestic partner has legal guardianship shall be treated the same as any other child.

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b. A domestic partner's or a domestic partner's child's coverage ends on the date of dissolution of the domestic partnership.

c. To apply for coverage as domestic partners, both the subscriber and the eligible domestic partner are required to complete and sign an enrollment application, meet all criteria stated on the enrollment application and submit the enrollment application to the Exchange. The Exchange will make the ultimate decision in determining eligibility of the domestic partner.

3) The subscriber's or the subscriber's spouse's children, including stepchildren, newborn and legally adopted children who are under age 26.

4) Children for whom the subscriber or the subscriber's spouse is a legal guardian and who are under age 26.

Eligibility will be continued past the age limit only for those already enrolled dependents who cannot work to support themselves by reason of intellectual or physical disability. These dependents must be allowed as a federal tax exemption by the subscriber or subscriber's spouse. The dependent's disability must start before the end of the period he or she would become ineligible for coverage. The Plan must certify the dependent's eligibility. The Plan must be informed of the dependent's eligibility for continuation of coverage within 31 days after the dependent would normally become ineligible. You must notify us if the dependent's tax exemption status changes and if he or she is no longer eligible for continued coverage.

The Exchange may require the subscriber to submit proof of continued eligibility for any enrolled child. Your failure to provide this information could result in termination of a child's coverage.

Temporary custody is not sufficient to establish eligibility under your Contract.

Any foster child who is eligible for benefits provided by any governmental program or law will not be eligible for coverage under your Contract unless required by the laws of this state.

Open Enrollment

As established by the rules of the Exchange, Qualified Individuals are only permitted to enroll in a Qualified Health Plan (QHP), or as an enrollee to change QHPs, during the annual open enrollment period or a special enrollment period for which the Qualified Individual has experienced a qualifying event.

An annual open enrollment period is provided for Qualified Individuals and enrollees. Qualified Individuals may enroll in a QHP, and enrollees may change QHPs at that time according to rules established by the Exchange.

American Indians are authorized to move from one QHP to another QHP once per month.

Changes Affecting Eligibility and Special Enrollment

A special enrollment period is a period during which a Qualified Individual or enrollee who experiences certain qualifying events or changes in eligibility may enroll in, or change enrollment in, a QHP through the Exchange, outside of the annual open enrollment period.

Length of special enrollment periods: Unless specifically stated otherwise, a Qualified Individual or enrollee has 60 calendar days from the date of a triggering event to select a QHP.

The Exchange must allow Qualified Individuals and enrollees to enroll in or change from one QHP to another as a result of the following triggering events:

- A Qualified Individual or dependent loses minimum essential coverage;
- A Qualified Individual gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption;
- An individual, not previously a citizen, national, or lawfully present gains such status;
- A Qualified Individual's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of an error of the Exchange or the Department of Health and Human Services (HHS), or its instrumentalities as determined by the Exchange. In such cases, the Exchange may take such action as may be necessary to correct or eliminate the effects of such error;
- An enrollee demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;
- An individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a QHP;
- The Exchange must permit individuals whose existing coverage through an eligible employer sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan;
- A Qualified Individual or enrollee gains access to new QHPs as a result of a permanent move; and
- A Qualified Individual or enrollee demonstrates to the Exchange, in accordance with HHS guidelines, that the individual meets other exceptional circumstances as the Exchange may provide.

Qualified Individuals are free to move between metal levels during special enrollment periods.

Newborn and Adopted Child Coverage

Newborn children of the subscriber or the subscriber's spouse will be covered for an initial period of 31 days from the date of birth. Coverage for newborns will continue beyond the 31 days, provided the subscriber with other than family coverage submits through the Exchange a form to add the child under the subscriber's Contract. The form must be submitted along with the additional premium, if applicable, within 60 days after the birth of the child.

A child will be considered adopted from the earlier of: (1) the moment of placement for adoption; or (2) the date of an entry of an order granting custody of the child to you. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption.

Adding a Child due to Award of Guardianship

If a subscriber or the subscriber's spouse files an application for an appointment of guardianship for a child, an application to cover the child under the subscriber's Contract must be submitted to Anthem within 60 days of the date of the appointment of guardianship. Coverage will be effective on the date the appointment of guardianship is awarded by the court.

Qualified Medical Child Support Order

If you are required by a Qualified Medical Child Support Order or court order, as defined by applicable state or federal law, to enroll your child under your Contract, and the child is otherwise eligible for the coverage, you must request permission from the Exchange for your child to enroll under your Contract, and once approved by the Exchange, we will provide the benefits of your Contract in accordance with the applicable requirements of such order.

A child's coverage under this provision will not extend beyond any dependent age limit. Any claims payable under your Contract will be paid, at Anthem's discretion, to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. We will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to Anthem directly.

Effective Date of Coverage

The earliest effective date for the annual open enrollment period is the first day of the following benefit year for a Qualified Individual who has made a QHP selection during the annual open enrollment period. A subscriber's actual effective date is determined by the date he or she submits a complete application to the Exchange.

Effective dates for special enrollment periods:

1. In the case of birth, adoption or placement for adoption, coverage is effective on the date of birth, adoption, or placement for adoption. Advance payments of the premium tax credit and cost-sharing reductions, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month; and
2. In the case of marriage, or in the case where a Qualified Individual loses minimum essential coverage, coverage is effective on the first day of the following month.

Effective dates for loss of minimum essential coverage includes loss of eligibility for coverage as a result of:

1. Legal separation or divorce;
2. Cessation of dependent status, such as attaining the maximum age;
3. Death of an employee or subscriber;
4. Termination of employment;
5. Reduction in the number of hours of employment; or
6. Any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
   - Individual who no longer resides, lives or works in the Plan's service area,
   - A situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits,
   - A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual,
   - Termination of employer contributions, and
   - Exhaustion of COBRA benefits.

Effective dates for loss of minimum essential coverage does not include termination or loss due to:

1. Failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or
2. Situations allowing for a rescission such as fraud or intentional misrepresentation of material fact.

Guaranteed Renewable

Coverage under your Contract is guaranteed renewable, provided the member is a Qualified Individual as determined by the Exchange. The member may renew the Contract by payment of the renewal premium by the end of the grace period of the premium due date, provided the following requirements are satisfied:

1. Eligibility criteria as a Qualified Individual continues to be met;
2. There are no fraudulent or intentional material misrepresentations on the application or under the terms of this coverage, subject to the incontestability provision;
3. Your Contract has not been terminate by the Exchange.

Network Services and Benefits

Note: Services will only be covered services if rendered by providers located in the State of Missouri, unless:

- **The services are for emergency care, urgent care and ambulance services; or**
- **The services are approved in advance by Anthem.**

If your care is rendered by a primary care physician (PCP), specialty care physician (SCP), or another in-network provider, benefits will be paid at the network level and you will not be financially responsible for any covered services that Anthem determines are not medically necessary. However, regardless of medical necessity, no benefits will be provided for care that is not a covered service even if performed by a PCP, SCP, or another in-network provider. All medical care must be under the direction of physicians. We determine the medical necessity of the service. We may inform you that it is not medically necessary for you to receive services or remain in a hospital or other facility. This decision is made upon review of your condition and treatment. You may appeal this decision.

In-network providers include PCPs, SCPs, other professional providers, hospitals, and other facility providers who contract with Anthem to perform services for you. PCPs include general practitioners, internists, family practitioners, pediatricians, obstetricians & gynecologists, geriatricians or other Network providers as allowed by the Plan. The PCP is the physician who may provide, coordinate, and arrange your health care services. SCPs are Network physicians who provide specialty medical services not normally provided by a PCP.

For services rendered by in-network providers:

- You will not be required to file any claims for services you obtain directly from in-network providers. In-network providers will seek compensation for covered services rendered from Anthem and not from you except for approved deductibles, coinsurance and/or copayments. You may be billed by your in-network provider(s) for any non-covered services you receive or when you have not acted in accordance with your Contract.
- When required, prior approval of benefits is the responsibility of the in-network provider. See the “Requesting Approval for Benefits” section.

If there is no in-network provider who is qualified to perform the treatment you require, contact Anthem prior to receiving the service or treatment and Anthem may approve a non-network provider for that service as an authorized service. Non-network providers are described below.

Non-Network Services

Covered services which are not obtained from a PCP, SCP or another in-network provider or not an authorized service will be considered a non-network service. The only exceptions are emergency care and urgent care.

For services rendered by a non-network provider, you are responsible for:

- The difference between the actual charge and the maximum allowed amount plus any deductible and/or copayments/coinsurance;
- Services that are not medically necessary;
- Non-covered services;
- Filing claims; and
- Higher cost-sharing amounts

How to Find a Provider in the Network

There are three ways you can find out if a provider or facility is in the network for this Plan. You can also find out where they are located and details about their license or training.

- See your Plan’s directory of in-network providers at anthem.com, which lists the doctors, providers, and facilities that participate in this Plan’s network.
- Call Customer Service to ask for a list of doctors and providers that participate in this Plan’s network, based on specialty and geographic area.
- Check with your doctor or provider.

If you need help choosing a doctor who is right for you, call the Customer Service number on the back of your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

Requesting Approval for Benefits

Your Contract includes the processes of Precertification, Predetermination and Post Service Clinical Claims Review to decide when services should be covered by your Plan. Their purpose is to aid the delivery of cost-effective health care by reviewing the use of treatments and, when proper, the setting or place of service that they are performed. Covered services must be medically necessary for benefits to be covered. When setting or place of service is part of the review, services that can be safely given to you in a lower cost setting will not be medically necessary if they are given in a higher cost setting.

Prior Authorization: In-network providers must obtain Prior Authorization in order for you to get benefits for certain services. Prior Authorization criteria will be based on many sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. Anthem may decide that a service that was first prescribed or asked for is not medically necessary if you have not first tried other medically necessary and more cost-effective treatments.

If you have any questions about the information in this section, you may call the Customer Service phone number on the back of your Member Identification Card.

Types of Requests

- **Precertification –** A required review of a service, treatment or admission for a benefit coverage determination which must be done before the service, treatment or admission start date. For emergency admissions, you, your authorized representative or doctor must tell us within 48 hours of the admission or as soon as possible within a reasonable period of time. For labor / childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time.
- **Predetermination –** An optional, voluntary Prospective or Continued Stay Review request for a benefit coverage determination for a service or treatment. We will check your Contract to find out if there is an exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to decide whether the service meets the definition of medical necessity under your Contract or is experimental/investigative as that term is defined in your Contract.
- **Post Service Clinical Claims Review –** A Retrospective review for a benefit coverage determination to decide the medical necessity or experimental/investigative nature of a service, treatment or admission that did not need Precertification and did not have a Predetermination review performed. Medical reviews are done for a service, treatment or admission in which we have a related clinical coverage guideline and are typically initiated by us.

Typically, in-network providers know which services need Precertification and will get any Precertification or ask for a Predetermination when needed. Your primary care physician and other in-network providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering provider, facility or attending doctor will get in touch with us to ask for a Precertification or Predetermination review ("requesting provider"). We will work with the requesting provider for the Precertification request. However, you may choose an authorize representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

Your Rights and Responsibilities

As a member, you have certain rights and responsibilities to help make sure that you get the most from this Plan. It helps you know what you can expect from your overall health care benefit experience and become a smarter health care consumer.

You have the right to:

- Speak freely and privately with your doctors and other health professionals about all health care options and treatment needed for your condition, no matter what the cost or whether it is covered under your Plan.
- Work with your doctors in making choices about your health care.
- Be treated with respect and dignity.
- Maintain privacy of your personal health information, as long as it follows State and Federal laws and our privacy policies.
- Get information about our company and services, and our network of doctors and other health care providers.
- Get more information about your Rights and Responsibilities and give us your thoughts and ideas about them.
- Give us your thoughts and ideas about any of the rules of this Plan and in the way it works.
- Make complaints or appeal about: our organization, any benefit or coverage decisions we make, your coverage, or care received.
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future; and the right to have your doctor tell you how that may affect your health now and in the future.
- Get up-to-date information about the cause of your illness, your treatment and what may result from that illness or treatment from a doctor or other health care professional. When it seems that you will not be able to understand certain information, that information will be given to someone else that you choose.

You have the responsibility to:

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

Exclusions

This list includes some of the more common services not covered by these plans:

- For services rendered by providers located outside the State of Missouri unless:
  1. The services are for emergency care, urgent care and ambulance services; or
  2. The services are approved in advance by Anthem.
- Acupuncture
- Artificial insemination, fertilization, infertility drugs or sterilization reversal
- Alternative or complementary medicine
- Artificial and mechanical hearts
- Bariatric surgery
- Benefits covered by Medicare or a governmental program
- Breast reduction or augmentation mammoplasty is excluded unless associated with breast reconstruction surgery following a medically necessary mastectomy resulting from cancer
- Care provided by a member of your family
- Care received in an emergency room that is not emergency care, except as specified in your Contract
- Charges incurred prior to the effective date of coverage or after the termination date of coverage
- Charges greater than the maximum allowable amount (charges exceeding the amount Anthem recognizes for services)
- Comfort and/or convenience items
- Cosmetic surgery and/or treatment that's primarily intended to improve your appearance
- Custodial care
- Dental, except as described in your Contract
- Educational services
- Experimental or investigative treatment
- Infertility testing and treatment
- Nutritional and dietary supplements
- Over-the-counter drugs, devices or products
- Pharmacy except as spelled out in your Contract
- Routine foot care
- Sclerotherapy (a medical procedure used to eliminate varicose veins and spider veins)
- Services we determine aren't medically necessary
- Sex transformation surgery
- TMJ and Craniomandibular Joint Disorders
- Vision except as described in your Contract
- Weight loss programs or treatment of obesity except as mandated
- Workers' compensation

Limitations

These services are limited as described below:

- Accidental dental injury benefit limit – maximum of $3,000 per accident
- Therapy services
  - Physical therapy – 20 visits per member per year
  - Occupational therapy – 20 visits per member per year
- Chiropractic – 26 visits for manipulation per member per year
- Rehabilitation
  - Cardiac – 36 visits
  - Pulmonary – 20 visits
  - Inpatient – 60 days
- Home health care – 90 visits
- Private duty nursing – 82 visits per year, 164 visits per lifetime
- Skilled nursing facility – 90 days
- Transplants – per transplant
  - Transportation and lodging - limited to $10,000
  - Donor search – limited to $30,000

This document is only a brief summary of benefits and services. Our plans have exclusions, limitations and terms under which the contract may be continued in force or discontinued. For more complete details including what's covered and what isn't:

- Call your Anthem authorized representative.
- Go to anthem.com.

For more information on how to access a Summary of Benefits and Coverage (SBC), please visit www.healthcare.gov and enter SBC in the search field.

Anthem Blue Cross and Blue Shield is a Qualified Health Plan in the Health Insurance Marketplace.

Selecting health coverage is an important decision.

To assist you, we supply the following for the plans under consideration: Brochure, Benefit Snapshot, Coverage Brief and Enrollment Application. If you did not receive one or more of these materials, please contact your Anthem authorized representative to request them.

In Missouri, (excluding 30 counties in the Kansas City area) Anthem Blue Cross and Blue Shield is the trade name of RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. Independent licensees of the Blue Cross and Blue Shield Association. ®ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.