



■ Ready to choose *your benefits?*

We can point you in the right direction.

HSA With Incentives
2018



Let's take a look

We know picking a health plan is a big deal, so this guide makes it easier for you to understand your benefit options. We'll explain how the plans work and give you other important details. That way you can enroll with confidence!

In this guide, you'll find:

- How to use your health plan
- Your privacy and rights

Pay a visit to [anthem.com](https://www.anthem.com) to get an idea of what you can do once you're a member. Find a doctor, estimate care costs, sign up to get emails instead of mail and much more!





Using your health plan

How to get started with your plan and make the best of your benefits



Choose a doctor in your plan

Avoid getting care from doctors outside of your plan; it will cost you more or your plan may not cover it at all. We've made it easy for you to find doctors in your plan. Just use our **Find a Doctor** tool on **anthem.com** to look for a primary care doctor, hospitals, labs and other health care professionals in your plan.



Get your ID card

After you enroll in a plan, you can access your mobile ID card on the Anthem Anywhere mobile app. It's like your passport to care since you'll need to show it whenever you go to the doctor.



Anthem.com

No matter which plan you choose, you can register at **anthem.com** or on the Anthem Anywhere mobile app to get personalized information about your health plan. Use the self-service tools to:

- Find a doctor.
- Estimate your costs, before you step into the doctor's office.

Learn more at **anthem.com/guidedtour**.



Preventive care is covered at no extra cost

Preventive care from a doctor in your plan is covered at 100%. Getting these regular checkups, screenings and shots can help you stay healthy and catch problems early – when they're easier to treat. So, talk to your doctor about what preventive care you may need to protect your health.



Save emergency room visits for emergencies only

Knowing where to go for care saves you time and money. So if you have a real emergency, head straight to the ER or call 911. Otherwise, visit your regular doctor or an urgent care center for minor medical issues.



We're here for you

When you become a member, you can get your questions answered in the way that works best for you.

- **By phone:** Call the Member Services number on your mobile ID card.
- **Online:** Register at **anthem.com** or download the Anthem Anywhere mobile app to chat with a team member.

Your plan details

In this next section, you'll find more information about your plan. 

Find the answers here

Frequently asked questions (FAQs) about your CDHP with HSA

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Health savings account (HSA)

Q. What is a health savings account (HSA)?

- A. An HSA is a special tax-sheltered savings account used with medical plans called consumer-driven health plans (CDHPs). By law, to open or contribute to an HSA, the medical plan must be a qualified “high-deductible health plan.” This means the deductible is higher than a traditional medical plan’s deductible. You can use the money in your HSA to help pay your deductible, your coinsurance and other qualified in-network or out-of-network expenses. You can also save money in your health savings account for future health care costs. The account grows with interest. And you have investment options after your account reaches a minimum balance of \$1,000. The HSA belongs to you and the money in the account is yours to keep, even if you leave your employer.

Q. How is my HSA funded?

- A. Your HSA is funded by your own pre-tax contributions, up to a certain annual limit. You may also contribute money to your HSA after taxes are taken out. Others (including your employer) may contribute to your account as well. You also can earn more dollars for your HSA by taking certain steps to improve your health. The total of all contributions cannot be more than the maximums defined by the U.S. Treasury and the Internal Revenue Service (IRS). (See the question below: How much can I contribute to my HSA? for details.)

Q. Who can open an HSA?

- A. To be eligible, you must meet the following criteria:
- You must be covered by an HSA-compatible health plan, such as the CDHP with HSA plan, and you cannot be covered by any other medical plan that is not an HSA-compatible health plan. This would include being enrolled in your spouse’s plan as secondary coverage. Federal law requires minimum deductible levels for individual and family coverage for HSA-compatible health plans.



- You must be enrolled in the plan on the first day of the month; otherwise, your eligibility to make contributions to your HSA begins the first day of the following month. You may make the maximum annual HSA contribution for the year regardless of the month you become eligible. You must remain enrolled in the HSA-compatible health plan for 12 months of the following tax year.
- You have no other health coverage except what is permitted under Other health coverage, defined in publication 969.
- You aren't enrolled in Medicare.
- You can't be claimed as a dependent on someone else's 2016 tax return.

The IRS has specific rules on who can open an HSA. See those rules in [**IRS Publication 969**](#).¹

Q. Can I enroll in the CDHP with HSA if my spouse is on Medicare?

- A. Yes, as long as you are not enrolled in Medicare and you meet the IRS eligibility requirements for an HSA, you can enroll in the CDHP with HSA. You can contribute to an HSA and you may choose to cover your spouse on your plan and use the funds in your HSA to pay for qualified medical expenses for you and your spouse on Medicare.

Q. My spouse is enrolled in Medicare. Can he or she also be enrolled as a dependent on the CDHP with HSA?

- A. Yes, but your spouse cannot open an HSA account in his or her own name because he or she is on Medicare. You may use the funds in your HSA to pay for qualified medical expenses for you and your spouse on Medicare.

Q. If my spouse is on Medicare and I am not on Medicare, how much can I contribute to an HSA?

- A. If you are enrolled in family coverage (two or more people), the IRS will only allow you to set up an HSA. You may contribute up to \$6,900 in 2018. You can use the HSA funds to pay for your spouse's out-of-pocket expenses, even if he or she is on Medicare.

Q. I am enrolled in Medicare Part A as I continue to work. Can I enroll in the CDHP with HSA?

- A. Yes, you can enroll in the CDHP with HSA if you have Medicare Part A. However, you will not be eligible to make contributions to the HSA.

Q. Who can use the money in an HSA?

- A. The money can be used for qualified health care costs for you, your spouse or any IRS-qualified dependent who you claim on your income taxes, whether or not he or she is covered on your health care plan. Talk with a tax advisor to find out if these rules apply to your tax situation. You can also go to irs.gov to find out who qualifies as a dependent.

You may not use the HSA funds for health care costs for a domestic partner or child who does not qualify as your tax dependent. If your domestic partner is covered by your CDHP with HSA plan, he or she can set up his or her own HSA at a financial company that manages HSA plans.

Payments for a dependent who doesn't meet the definition of "tax dependent" may be considered nonqualified costs. This means you may have to pay taxes and penalties for these payments. For more details about eligible expenses and dependents for HSAs, see [**IRS Publication 969**](#).¹ Keep in mind that this document changes regularly and you should check with your tax adviser if you have questions.

Q. I am enrolled in the CDHP with HSA. Can I continue to contribute to my spouse's HSA and use his or her bank?

- A. You and your spouse can continue to make contributions to his or her HSA, but you cannot contribute more than the IRS family contribution maximum between both HSA accounts. For 2018, the family contribution maximum is \$6,900.

Q. My child is under 26 but I no longer claim him or her on my taxes. Can I cover him or her on the CDHP with HSA?

- A. The IRS has specific rules about covering a child. See [IRS Publication 969](#).¹ You can cover dependents under age 26 in the CDHP with HSA, but you can't use your HSA account for their expenses unless they meet the following requirements:
- Account holder must be able to claim the child on his or her tax return.
 - Your child is under age 19 or under age 24 if a full-time student, or totally and permanently disabled.

Dependents who do not qualify to receive funds from your HSA may qualify to open their own HSA and could be permitted to contribute up to the family maximum (for 2018, this is \$6,900). They can contact a financial institution to discuss how to set up a separate HSA.

Q. My child is under age 26 and married. Can I cover him or her on my medical plan?

- A. Yes, eligible dependents can be covered to the age of 26. Under health care reform, this applies to all dependent children up to age 26, regardless of student, employment, residential or marital status.
- The health care reform law expanded the definition of eligible dependents to age 26 for medical plan coverage, FSAs and health reimbursement accounts (HRAs).
 - The law did not expand the definition of eligible dependent to age 26 for HSA expenses. Therefore, employees can use HSA funds tax-free only for eligible expenses of family members who meet the definition of a "tax dependent" in the Internal Revenue Code. Please refer to the previous Q&A.
 - Disbursements for children who don't meet this stricter definition may be considered nonqualified expenses, which are subject to tax and penalties. That means you'll pay a penalty plus taxes if you use the pretax dollars from your HSA to pay health expenses for your older covered dependent if he or she does not meet the IRS definition of a tax dependent.
 - Please refer to the [IRS Publication 969](#)¹ for more information or speak with your tax adviser.

Q. I do not have custody of my two children. I do not claim them on my tax return. Can I use funds in my HSA to pay for their qualified health care costs?

- A. For purposes of medical and dental expense deductions, a child of divorced or separated parents can be treated as a dependent of both parents. Each parent can include the health care costs he or she pays for the child, even if the other parent claims the child's dependency exemption, if:
- The child is in the custody of one or both parents for more than half the year.
 - The child receives more than half of his or her support during the year from his or her parents.
 - The child's parents:
 - Are legally divorced or separated.
 - Are separated under a written agreement.
 - Lived apart at all times during the last six months of the year.

This does not apply if the child's exemption is being claimed under a multiple support agreement.

To find out more about covering children and children of divorced or separated parents, please see [IRS Publication 969](#)¹ and talk with a tax adviser.

Q. If I am covering a child who is age 23 and I cannot claim him or her as a tax dependent, what is my maximum contribution to an HSA on a pretax basis?

- A. If the child cannot be claimed as a tax dependent, the child is eligible to establish his or her own HSA and can contribute up to the family maximum (\$6,900 for 2018). The employee also can contribute up to the family maximum in his or her HSA in this example.

Q. I have an HSA with another bank. Can I keep it? Do I have to open an account with your partner bank?

- A. You can keep the HSA account you have. But, all contributions from your paycheck will only go to your employer-sponsored HSA. Also, you will have to pay any bank charges for your other HSA.

Q. What is the difference between an HSA and a health care flexible spending account (FSA)?

- A. Both HSAs and FSAs can be funded with pre-tax dollars and be used to pay for medical expenses. However, HSA balances can roll over from year to year, while FSA money is forfeited if it is not spent during a 12-month period. And, if you leave your employer, your HSA dollars are yours to keep. FSA dollars are forfeited.

Q. Can I have an HSA and an FSA?

- A. Yes, you are eligible to have both an HSA and an FSA only if the FSA has been defined as either a:
- **Limited/Special Purpose FSA**, which may be limited to dental or vision services.
 - **Limited Purpose High-Deductible FSA**, which also allows for dental or vision services, as well as paying for coinsurance under the traditional health component of the plan, after meeting the deductible.

Making contributions to your HSA

Q. How do I make contributions to my HSA?

- A. If your employer allows it, the easiest way is through pretax payroll deductions. However, you may also contribute directly to your HSA after taxes. To make after-tax contributions, call your HSA financial company or go online to the financial company's member website and set up an electronic fund transfer from your personal bank account.

Q. How much can I contribute to my HSA?

- A. The annual contribution maximum in 2018 is \$3,450 for individual coverage and \$6,900 for family coverage. The maximums are set by the U.S. Treasury and the IRS. Those maximums may go up every year for inflation. Check [irs.gov](https://www.irs.gov) for the most current maximum amounts.

Q. Can I ever contribute more than the annual limit?

- A. Yes, people aged 55 and older who are not enrolled in Medicare can contribute an extra \$1,000 above the regular limits. This is called a "catch-up contribution." These individuals can make catch-up contributions each year until they enroll in Medicare.

Only the account holder can make catch-up contributions. The contribution amounts allowed are subject to proration if you are enrolled in the plan less than 12 months or under other circumstances. Catch-up contributions can be made in the same way your regular contributions are made.

Q: If I am 55 and older and my spouse is too, can we both make catch-up contributions?

- A. If only one spouse has an HSA in his or her name, only that spouse can make a catch-up contribution. If both of you want to make catch-up contributions when you are age 55 or older, you must establish separate HSA accounts. Please note the contribution combined cannot be more than the IRS family contribution maximum.

Q. What if I contribute too much to my account during a year and go over the annual maximum allowed?

- A. If you contribute too much to your account, IRS rules require that you pay regular income tax, plus a tax penalty on the amount you went over. If you realize you've contributed too much before you file your taxes, you may choose to submit a form showing these contributions to the HSA financial company to remove those excess funds. Different rules apply if you contributed too much because you left the plan during the year. See the question *What if I end my coverage before the end of the year?* to find out more.

Q. What if I end my coverage before the end of the year?

- A. You take that money with you wherever you go. The HSA is in your name and it's your account. If you're on Medicare or go to another employer who doesn't have a qualified high-deductible health plan, you can still use your HSA money to pay for copays and qualified medical expenses. However, you won't be able to continue to make contributions to your HSA unless you continue to participate in an HSA-compatible plan.

If you leave during the year and do not enroll in another HSA-compatible plan, the annual contribution maximum is prorated. This is based on the number of months that you were enrolled in an HSA-compatible plan. If you fund your account for the entire year, then leave the plan and do not join another HSA-compatible health plan, you will need to withdraw the excess funds before the end of the tax year. You'll have to treat these funds as taxable income if you have over-funded the account. If you don't, you may have to pay tax penalties.

For example, let's say Mary was enrolled in the CDHP with HSA and changes jobs on July 1, 2018, and is no longer eligible to contribute to her HSA. She would figure out her health savings maximum contribution amount for that year this way:

$$\$3,450 \times 6 \text{ months} / 12 \text{ months} = \$1,725$$

You can contact your HSA financial company if you have questions about your account.

Q. What if my spouse has an HSA, too?

A. The chart below explains different situations:

If your spouse:	And you have:	Then, the IRS:
Has PPO (preferred provider organization) self + children coverage.	HDHP (high-deductible health plan) self-only coverage.	Treats you as having single coverage and only you may set up an HSA (health savings account). You may contribute up to \$3,450.
Has HDHP self-only coverage with a \$1,500 deductible.	HDHP self + child coverage with a \$3,000 deductible.	Treats you both as having family coverage, and combined you may contribute up to \$6,900 to an HSA.
Has HDHP self + family coverage with a \$3,000 deductible.	HDHP self + spouse coverage with a \$3,000 deductible.	Treats you both as having family coverage, and combined you may contribute up to \$6,900 to an HSA.
Is enrolled in Medicare.	HDHP self + family coverage only.	Will only allow you to set up an HSA. You may contribute up to \$6,900.

Q. Does tax filing status (joint vs. separate with my spouse) affect my HSA contribution?

A. Tax filing status does not affect your contribution. The IRS requirements simply refer to eligible expenses for the "spouse" — they do not include requirements for filing jointly or separately. However, the IRS indicates that children must be tax dependents. [IRS Publication 969](#)¹ has more details. See the question *I do not have custody of my two children* to learn more.

Q. Can I use the HSA account for eligible expenses for my spouse even if we file our taxes separately?

A. Yes, the IRS requirements simply refer to eligible expenses for the "spouse" — they do not include requirements for filing jointly or separately. However, the IRS indicates that children must be tax dependents. IRS Publication 9691 has more details.

Q. I am going to enroll in the CDHP with HSA. What happens if my spouse chooses coverage under a health care FSA?

A. Usually, a health care FSA covers the expenses of the participant and the participant's spouse and dependents. If your spouse has a health care FSA, most likely your health care costs are covered under your spouse's FSA. If so, then you won't be able to make contributions to your HSA.

There are exceptions to this rule. For example, if your spouse's FSA is a limited-purpose FSA that only covers dental and vision costs.

Q. Can I use my HSA to pay for medical expenses before I set up my account?

A. No. You cannot be reimbursed for qualified medical expenses before the date your HSA account is established.

Q. What happens if I have a medical expense early in the year and there isn't enough money in my HSA to cover my out-of-pocket costs?

A. The HSA works like a bank account. You can only spend what is in the account. However, you can start the reimbursement process for any services incurred after you enrolled in the HSA when you have more funds in your account.

Q. What counts toward my out-of-pocket maximum?

- A. The out-of-pocket maximum adds together your deductible and the percentage you shared in the cost for covered expenses (your coinsurance or portion of the cost). Once you reach the maximum out-of-pocket, the plan pays covered expenses at 100% for the rest of the year.

It's very important to understand that if the provider's charge is more than our maximum allowed amount for out-of-network services, you will be responsible for paying the difference. Out-of-network providers can bill you for balances above the amount your plan pays, even if you've paid your out-of-pocket maximum.

Q. Are deductibles included in the out-of-pocket maximum for the CDHP with HSA?

- A. Yes, deductibles and coinsurance for your medical and pharmacy costs are included in the out-of-pocket maximum. This includes your prescription drug costs.

Q. Once I reach my out-of-pocket maximum, do I still have to pay for office visits and prescriptions?

- A. No. Once you meet your out-of-pocket maximum, the plan pays 100% for covered expenses. If you use out-of-network providers they can bill you for the amount above what we allow and this will be your responsibility to pay.

Q. Are dental and vision care considered qualified medical expenses for purposes of a health savings account?

- A. Yes, many dental, orthodontia and eye care expenses are considered qualified medical expenses. However, cosmetic procedures, like cosmetic dentistry, would not be considered a qualified medical expense. For a detailed list, please see [IRS Publication 502](#).²

Q. What if I have money left in my HSA at the end of each plan year?

- A. Whatever you don't spend is yours to keep and save year after year. Your HSA can help you pay for future health care costs.

Q. How can I find out more about HSA regulations?

- A. Go to the U.S. Treasury website at [treasury.gov](https://www.treasury.gov) and type HSA in the search box. You may also read [IRS Publication 969](#).¹

Services covered by your medical plan

Q. What is traditional health coverage?

- A. Once you meet your deductible in a CDHP with HSA plan, the plan works like a preferred provider organization (PPO) plan. You pay coinsurance (a percentage of what the provider can charge) when you go to a network provider. You'll pay more if you go to a provider who is not in the network. Check your plan summary to find out more about coinsurance.

Q. What services does the CDHP with HSA plan cover?

- A. It covers services that are usually covered by a typical health plan. That includes things like office visits, prescription drugs and major surgeries. Check your plan summary to see some of the services covered by your plan.

You can use your HSA to pay for qualified health care costs not covered by your plan. For a list of qualified medical expenses, see [IRS Publication 502](#).²

Q. What about preventive care services like mammograms and checkups?

- A. The medical plans cover preventive care services like checkups, vaccines and mammograms at 100% when you use a provider in the network. You won't have to pay anything out of your own pocket when you get care from a network provider. You may choose to use your HSA funds to cover these costs.

Q. How do I know what is considered preventive care?

- A. Our medical plans cover preventive care services like checkups, vaccines and mammograms at 100% when you see a network provider. Your Summary Benefit Description shows which services are covered by your plan. In addition, this brochure gives you a general understanding of what is covered under preventive services.

Managing the money in your HSA

Q. Who holds the money in my HSA?

- A. A qualified financial institution holds it and handles those records. If your employer selects an Anthem partner bank, we will handle all of the enrollment administration for you.

Q. How do I find out my HSA balance?

- A. It's easy. First register at anthem.com after you get your medical ID card. Then, log in and go to the bank website. There, you can see your account balance, transactions and manage your personal information online.

Q. Will I have to register to use the site the first time I log in to the bank website through HSA bank website?

- A. Yes, the first time you go to the HSA bank website from anthem.com, you will need to set up a username and password. After you do that, you will be able to use the banking site member website through anthem.com. Also, you will be able to use the bank website username and password to access your information directly through their website and through their mobile application.

Q. How do I access the money in my HSA?

- A. You will receive a debit card to use to pay for eligible expenses when funds are available. You also can make payments online at the HSA bank website. You can pay the provider directly or get reimbursed for an eligible cost online.

Q. Will my HSA earn interest?

- A. Yes. The HSA is an interest-bearing account.

Q. Can I invest my HSA?

- A. Yes. You'll need to have at least \$1,000 in your HSA before you can invest it. You can invest in certain mutual funds after you reach the \$1,000 minimum balance in your account.

Q. Are the interest and investment earnings in my HSA tax-free?

- A. Yes, when the funds are distributed and used for qualified health care costs. Interest and investment earnings grow tax-deferred in the account. That means you'll only be taxed if funds are withdrawn for non-health care costs.

Q. Are any administrative fees charged to my HSA?

- A. Yes, you'll have to pay banking fees, such as overdraft charges or charges for debit cards to replace lost ones. When you enroll in the program, you will get information about the account.

Q. Is there a time restriction on when I may use the funds in the account?

- A. No. Once funds are put into the HSA, they may be used at any time in the future for qualified health care costs.

Q. If I leave the medical plan, what happens to my HSA?

- A. You own the HSA; the money is yours to keep. You may choose to keep the funds in your account or roll the funds into a different account. If you leave the funds in your account, you will have to pay fees to keep it. If you retire and are insured by Medicare, change to a health plan that is not an HSA-compatible plan or go to another employer that doesn't offer an HSA-compatible plan, you can still use your HSA to pay for out-of-pocket qualified health care costs. But you won't be able to continue to make contributions to your HSA.

Q. Can I roll over funds from my HSA to another HSA if I leave the program?

- A. Yes. Contact your new HSA administrator for help with the rollover process.

Q. What if I use HSA funds to pay for nonqualified health care costs?

- A. If you realize you've used HSA funds for nonqualified health care costs before you file your taxes, you can fill out a form showing these contributions, along with a check to put the funds back in your HSA. If you've filed your taxes and did not return the funds, the amount you spent on the nonqualified expense will be considered part of your taxable income. You will also owe a 20% penalty on that amount if you are under age 65.

Q. Do I have to use funds from my HSA to pay for health care costs?

- A. No. You may pay out of pocket with after-tax dollars and let your HSA balance grow tax-free.

Tax benefits

Q. What are the tax benefits of an HSA?

- A. There are several benefits:
- Contributions to the account are (federal) tax-deferred or tax-advantaged.
 - Any investment and interest earned in your account are (federal) tax-deferred.
 - Withdrawals from the account for qualified health care costs are (federal) tax-free.
 - Depending on the state where you live, you may save on your state tax as well.

Choosing health care providers

Q. What is the difference between in-network and out-of-network providers?

- A. Network providers are doctors, hospitals, facilities and other health care providers who are part of the network. That means they have a contract with us and will accept the amount we allow as payment in full for certain covered services. This large network includes many providers and specialists so you find the care you need.

You can even find network care when you travel across the country with the BlueCard® PPO program, which is included with your plan. Just call **1-800-810-BLUE** if you need care away from home.

Out-of-network providers do not have a contract with us and have not agreed to accept the amount we allow as payment in full for specific covered services. This means out-of-network providers may charge more for services than what the network providers agree to accept. If you see an out-of-network provider, you'll pay a higher coinsurance, plus any provider charges above what we allow.

Q. How do I know if my doctor is in the network?

- A. You can search the provider network by going to [anthem.com](https://www.anthem.com) and selecting **Find a Doctor**. Follow the steps and select your plan. If you need more help, call the Member Services number on the back of your ID card.

- Q. If my doctor isn't in the network, can I still use his or her services?**A. You can go to any doctor you choose. And you don't need a referral to see a specialist. However, you'll save money when you go to a network doctor. Also, if you see an out-of-network doctor, you may have to file a claim yourself. You can download a claim form at [anthem.com](https://www.anthem.com).

Q. Can I go to any doctor or hospital when I travel away from home?

- A. Yes. Many providers throughout the country are part of the BlueCard PPO® program. To find a network doctor or hospital when you travel, call **1-800-810-BLUE**. However, if you see an out-of-network provider, you may end up paying more out of pocket.

Q. If I need to file a claim, how do I get reimbursed?

- A. In most cases, you won't need to file a claim if you go to a network provider. If you go to an out-of-network provider, you might have to file the claim. If so, send your claim to us for reimbursement. You can download a claim form at [anthem.com](https://www.anthem.com).

Prescription drug coverage

Q. Does the HSA plan cover prescription drugs?

- A. Yes, show your ID card when you go to your pharmacy. If you have funds in your HSA, you can choose to use your HSA debit card for your share of the cost at the pharmacy. You can also use your HSA debit card for your cost when you use the home delivery pharmacy service if you have funds available.

If you have used all of the funds in your HSA - or choose not to use these funds and save them for future use - you will have to pay out of pocket until you meet your annual deductible before the traditional health coverage part of the plan begins. Then, you will pay any coinsurance for your prescription drugs. Check your *Plan Summary* to find out more about your prescription drug benefits.

Q. Is there a preferred drug list for the HSA plan?

- A. No, you don't have to use medications from a preferred drug list.

Q. Do I need to get preauthorization for any drugs?

- A. Some medications are **not** covered unless you first get approval through a coverage review process. To save you time and help avoid any confusion, check to see if your medication requires coverage review (prior authorization) by calling Member Services at the number on your medical plan ID card..

Some medication may be covered, but they may have limits (like only for a certain amount or for certain uses and lengths of time) unless you get approval through a coverage review. Before the medication may be covered under your plan, we will ask your doctor for more information to make a decision.

Q. Do my prescription costs apply to my out-of-pocket maximum or my medical deductible?

- A. Yes, prescription drug costs apply to your annual deductible and the medical annual out-of-pocket maximum. Once you meet your deductible, you begin to pay the copay or coinsurance.

Q. How do I submit prescriptions to the home delivery pharmacy?

- A. Home delivery pharmacy is an easy and cost-effective way for you to get a medication for an ongoing condition. We encourage you to use the member website to download the most up-to-date home delivery order form, which will help speed up the processing of the home delivery prescription order. You can access and download the Express Scripts prescription order form by logging in to the anthem.com member website and selecting Pharmacy, which will take you to the Express Scripts website. Prescription order forms for home delivery are available to download from the site. You also will get a printed order form with each order that's filled by the Express Scripts pharmacy.

Q. Do I need to use a particular pharmacy for specialty drugs?

- A. Please contact Member Services to find out more about specialty drug coverage.

Q. How do I get the most out of my pharmacy benefits?

- A. There are a few key steps to take to get the most out of your pharmacy benefits:
- Show your ID card when you drop off your prescriptions.
 - Have your prescriptions filled at a participating pharmacy.
 - Ask for generic drugs to lower your out-of-pocket cost.
 - When possible, use the home delivery pharmacy for your prescriptions.

Health and wellness programs

Q. What health and wellness programs are available?

- A. The health and wellness programs listed below are available to you at no extra cost to you.
- **ConditionCare** — Helps members manage chronic conditions such as asthma, diabetes, heart failure, coronary artery disease (CAD) and chronic obstructive pulmonary disease (COPD).
 - **Future Moms** — Helps mothers-to-be make informed decisions for a healthy pregnancy and delivery.
 - **LiveHealth Online®** — Connect with board-certified doctors from your computer, tablet or mobile device 24/7.

Q. What are health and wellness programs?

- A. Our health and wellness programs provide you with resources, tools, guidance and support to help you manage your health and make more informed health care decisions. Just a few of the tools and health coaching programs are described below. Register and log in at anthem.com for more details.

Q. What is the Health Assessment?

- A. Our Health Assessment is an online health profile the you can complete in a few minutes. It helps you identify possible risk factors based on your current health, family history, lifestyle and other factors. And, like all tools at anthem.com, the Health Assessment is confidential. Your information is protected by the highest level of online security, and will not be shared with your employer. You and your covered family members may fill out the Health Assessment to get a snapshot of your health status and potential health risks.

Q. How does the Health Assessment help me earn rewards?

- A. You are eligible to earn \$50 in your HSA per plan year for completing the Health Assessment.

Q. What is the 24/7 NurseLine?

- A. 24/7 NurseLine is a service you can call to get answers to your immediate health care questions. Registered nurses are on hand to answer your calls 24 hours a day, 7 days a week.

What if I have questions?

Q. How does the money I contribute to my HSA help me save on taxes?

- A. Any money you contribute to your HSA is considered (federal) tax-deductible. That means it's not counted as taxable income for the year. So, if you put \$1,000 into your HSA, your adjusted gross income for the year is lowered by \$1,000, which could save what you owe for taxes, depending on your tax status.

Q. What should I do with the receipts for services I had?

- A. You should keep them. Since you own the HSA, you are responsible for giving documentation to the IRS, if you ever need to, for the expenses charged to your HSA. You can upload your receipts to the bank's member website and save them to your HSA member website. You can do this online or through your mobile phone.

Q. Are there any special instructions for filing my taxes?

- A. Yes. You will have to complete a *Form 8889* to report your HSA contributions and distributions when you file your taxes. Information from *Form 1099-SA* mailed to you by financial institution by early February shows annual distributions. You can find *Form 8889* and instructions at [irs.gov](https://www.irs.gov).

You'll receive *Form 5498-SA* from the HSA bank each May. It's for your information only. You don't need to file it with your tax return. And you'll need to keep track of your receipts for anything you pay for from your account in case you need to give documentation to the IRS to show you used any HSA funds on qualified health care costs. Please talk with a tax adviser to make sure you file your taxes correctly.

Q. Who do I contact if I have questions about my plan?

- A. Please contact us with any questions you have about your plan. You can reach Member Services by calling the number on the back of your ID card or visiting anthem.com. You and your family members should receive your ID cards by your effective date of coverage. If you don't receive them, or if you misplace one, please contact us.

Your privacy

Q. Is your website secure?

- A. Yes. Our customer-only website is secure and password-protected. Your personal information is kept safe using the highest encryption level available.

Q. What is your privacy policy?

- A. You can read the Privacy Policy anytime at anthem.com.

The information included does not constitute legal, tax, or benefit plan design advice. We strongly encourage you to consult with a tax adviser before establishing a health savings account. Any health savings account will be established between the individual account holder and the HSA custodian or trustee. Anthem is responsible for the administration of the health plan, and the custodian is responsible for the administration of the HSA.

1 <http://www.irs.gov/pub/irs-pdf/p969.pdf>

2 <http://www.irs.gov/pub/irs-pdf/p502.pdf>

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What's in your claim recap?

Each time you or a health care provider file a claim with your health plan, Anthem Blue Cross and Blue Shield (Anthem) gives you a claim recap. The recap helps you see how your Anthem Consumer-Driven Health Plan with health savings account (HSA) works for you. It describes the services received, what they cost and how your plan handled the claim.

Anthem BlueCross BlueShield
1351 William Howard Taft Rd
Cincinnati, OH 45206-0775

JOHN Q. MEMBER
2300 AVANT STREET
CLEVELAND, OH 44122

Account Holder:
John Q. Member
Health Program ID:
9998817749004
Group Name:
HSA Client
Claim Number:
199943200001
Date Prepared:
05/20/2014

To view your claim recap, log in to anthem.com and go to the *Claims* section. We'll also send a copy in the mail if you owe any money toward the claim. If you don't want to get a copy in the mail, see below for a quick how-to on going paperless.

Here are the key things to look for on your claim recap.

1 Summary of this claim

- Amount of the claim
- Amount you'll need to pay out of pocket, if any
- Amount that applies toward reaching the traditional health coverage portion of the plan — when you and the plan each pay a percent of the cost for covered services

2 Status of your program

Amount you've spent on covered services during the plan year — a good way to see how much is left before your traditional health coverage kicks in or you reach your annual out-of-pocket maximum

3 Claim payment details

A breakdown of the claim, including the amounts paid through traditional health coverage

1. Summary of this Claim (See next page for details)

How Much was the Expense?	
The total charge was:	\$ 150.00
Amount allowed by your benefit:	\$ 125.00
[Your Other Insurance Covered]	\$ 0.00

How Much was Paid Under Your Program?	
Amount paid by Traditional Health Coverage:	\$ 0.00
Total paid under your program:	\$ 0.00

What is Your Out-of-Pocket Responsibility? ¹	
Other out-of-pocket responsibility:	\$ 125.00
Coinsurance responsibility:	\$ 0.00
You are Responsible for This Amount:	\$ 125.00

Your Provider should bill you directly for this amount.

Claim Highlights

Date of Service:
05/03/2014
Consumer:
Mary Member
Provider:
Dr. James J. Smith
Vienna Family Medicine
123 Maple Avenue
Cleveland, OH 44117

Thank you for choosing a provider participating in our network — helping you get the most for your health care dollar.

Have a question?
Go online to anthem.com or call 1-800-000-0000.

Save trees by opting not to receive paper statements. You can simply check your account online at anthem.com.

2. Status of Your Program (After this Claim)²

Your Traditional Health Coverage	
Begins after spending (on covered services):	\$2,000.00
Amount spent to date:	\$ 125.00

Your Annual Out-of-Pocket Maximum	
Maximum for Network Providers:	\$3,000.00
Amount accumulated towards Maximum to date:	\$ 125.00
Maximum for Out-of-Network Providers:	\$5,000.00
Amount accumulated towards Maximum to date:	\$ 125.00

¹ Your out-of-pocket responsibility may increase if you do not use a participating network provider. Your out-of-pocket responsibility may increase if you receive a service that is not a covered benefit and may not apply to your out-of-pocket maximum.

² The information above is accurate as of this claim for the benefit year in which it occurred. It may not reflect your most recent account balance and claims activity. Your actual balance depends upon claims that are in process and on services you have received that are not yet processed.

Si necesita ayuda en español para entender este documento, la puede solicitar sin ningún costo adicional llamando sin cargo al 1(800) 000-0000.

3. Claim Payment Details

Health Care Provider Information				Your Program Traditional Health Coverage		Your Responsibility	Explanation**
Date of Service From: 05/03/2014 to 05/03/2014				Amount Paid	Benefit Level	You Are Responsible for	
Service (Units)	Provider Charged	Provider Responsibility	Amount Allowed by Benefit*				
1 Medical Service - 1	\$150.00	\$25.00	\$125.00	\$0.00		\$125.00	OPM
TOTAL	\$150.00	\$25.00	\$125.00	\$0.00		\$125.00	

For more information, call the Member Services number on your member ID card.

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How to get your health plan claim recaps online*

1. Log in to anthem.com (if you haven't registered yet, you'll need to register to log in).
2. Pick **Profile**.
3. Choose **Email Preferences**.
4. Select **Primary Email Address**.
5. Choose **Save/Update**.

* Only the primary person on the plan (the subscriber) can pick this option.

What you should know about qualified medical expenses for Health Savings Accounts

If you have a Health Savings Account (HSA) it's important for you to understand what a qualified medical expense is and how it relates to your account.

Background:

A Health Savings Account (HSA) is a tax-advantaged savings account combined with a High Deductible Health Plan. You can use your HSA to help meet your deductible by paying for medical expenses covered by your health plan. Some expenses may not be covered by your health insurance plan but can still be paid for using your HSA. The IRS considers these "qualified medical expenses" and are defined in Section 213(d) of the Internal Revenue Code.

What is a qualified medical expense?

- They're expenses that include amounts paid for the diagnosis, treatment or prevention of disease, and for treatments that affect any part or function of the body.
- The expenses must be used to prevent or relieve a physical defect or illness.
- They're expenses that would generally qualify for the medical and dental expenses deduction under tax advantaged accounts.
- HSA funds spent on non-qualified expense will be considered part of your taxable income. You will also owe a 20% penalty on that amount.

Whose expenses can be reimbursed?

The money in the HSA can be used to pay for qualified medical and/or dental expenses spent by the employee, spouse or a dependent for whom an exemption is claimed under Section 152 of the tax code. Expenses that occurred before

you established your HSA are not qualified medical expenses. Only expenses made after you open your HSA are qualified medical and/or dental expenses.

Be sure to keep complete records to show that:

- The money in the HSA was used only to pay for or reimburse qualified medical and/or dental expenses
- The qualified medical and/or dental expenses had not been previously paid for or reimbursed from another source
- The medical and/or dental expenses had not been taken as an itemized deduction in any year

Over-the-Counter (OTC) items impacted by health care law

Effective January 1, 2011 you will no longer be able to use funds from an HSA to purchase some OTC items that had been covered in the past. Please see the chart below for more detail.

Eligible over-the-counter items		
<ul style="list-style-type: none"> • Band aids • Birth control • Braces and supports 	<ul style="list-style-type: none"> • Contact lens solution and supplies • Elastic bandages and wraps 	<ul style="list-style-type: none"> • First aid supplies • Reading glasses
Ineligible over-the-counter medications (unless accompanied by a prescription)		
<ul style="list-style-type: none"> • Acid controllers • Acne medication • Allergy and sinus • Antibiotics • Anti-itch and insect bite 	<ul style="list-style-type: none"> • Cough, cold and flu medicine • Eye drops • Indigestion • Laxatives • Motion sickness • Nasal sprays 	<ul style="list-style-type: none"> • Ointments and creams • Pain relief • Respiratory treatments • Sleep aids and sedatives • Stomach remedies

Qualified medical expenses for Health Savings Accounts

Below are two charts that give examples of medical expenses that are eligible (do qualify) and are not eligible (do not qualify) for reimbursement. Please know that this is only a partial list and is not complete. The list is subject to change based on regulations, revenue rulings and case law. The list should be used only as a general guideline for covered expenses. All items on the list may be subject to further restrictions.

Eligible medical expenses		
<ul style="list-style-type: none"> • Abortion • Acupuncture • Alcoholism treatment • Ambulance • Anesthetist • Artificial limbs • Autoette (when used for relief of sickness or disability) • Birth control pills (by prescription) • Blood tests • Blood transfusions • Breast Reconstruction Surgery (following a mastectomy for cancer) • Cardiographs • Chiropractor • Christian Science practitioner • Contact lenses • Contraceptive devices (by prescription) • Crutches • Dental treatment 	<ul style="list-style-type: none"> • Dental X-rays • Dentures • Dermatologist • Diagnostic fees • Diagnostic Devices (used in diagnosing and treating illness and disease) • Drug addiction therapy • Drugs (prescription) • Eyeglasses • Fees paid to health institute prescribed by a doctor • Fertility Enhancement (procedures to overcome an inability to have children) • Hearing Aids • Guide dog • Gum treatment • Psychoanalysis • Psychologist 	<ul style="list-style-type: none"> • Psychotherapy • Radium therapy • Registered nurse • Special school costs for the handicapped • Spinal fluid test • Splints • Sterilization • Surgeon • Telephone or TV equipment to assist the hard-of-hearing • Therapy equipment • Transportation expenses (relative to health care) • Ultraviolet ray treatment • Vaccines • Vasectomy • Vitamins (if prescribed) • Wheelchair • X-rays
Ineligible medical expenses		
<ul style="list-style-type: none"> • Advance payment for services to be rendered next year • Athletic club membership • Automobile insurance premium allocable to medical coverage • Boarding school fees • Bottled water • Commuting expenses of a disabled person • Cosmetic surgery and procedures • Cosmetics, hygiene products and similar items 	<ul style="list-style-type: none"> • Funeral, cremation or burial expenses • Health programs offered by resort hotels, health clubs and gyms • Illegal operations and treatments • Illegally procured drugs • Maternity clothes • Non-prescription medication • Over-the-counter drugs • Premiums for life insurance, income protection, disability, loss of limbs, sight or similar benefits • Scientology counseling 	<ul style="list-style-type: none"> • Social activities • Special foods and beverages • Specially designed car for the handicapped other than an Autoette or special equipment • Swimming pool • Travel for general health improvement • Tuition and travel expenses to send a problem child to a particular school • Weight-loss programs

For more detailed information:

- Please refer to the publication put out by the IRS titled "Medical and Dental Expenses"; number 502, catalog number 15002Q.
- You can order a copy of the publication by calling 800-TAX-FORM (800-829-3676).
- Or you can view it online at www.irs.gov/pub/irs-pdf/p502.pdf.

**For tax advice, please
contact a tax professional.**

This content is provided solely for informational purposes. It is not intended as and does not constitute legal advice. The information contained herein should not be relied upon or used as a substitute for consultation with legal, accounting, tax and/or other professional advisors.

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Take care of yourself

Use your preventive care benefits

Getting regular checkups and exams can help you stay healthy and catch problems early — when they're easier to treat.

That's why our health plans offer all the preventive care services and immunizations below — at no cost to you.¹ As long as you see a doctor or use a pharmacy in the plan, you won't have to pay anything for these services and immunizations. If you want to visit a doctor or pharmacy outside the plan, you may have to pay out of pocket.

Not sure which services make sense for you? Talk to your doctor. He or she can help you figure out what you need.

Preventive vs. diagnostic care

What's the difference? Preventive care helps protect you from getting sick. If your doctor recommends you have services even though you have no symptoms, that's preventive care. Diagnostic care is when you have symptoms and your doctor recommends services to determine what's causing those symptoms.

Adult preventive care

Preventive physical exams

Screening tests:

- Alcohol misuse: related screening and behavioral counseling
- Aortic aneurysm screening (men who have smoked)
- Behavioral counseling to promote a healthy diet
- Blood pressure
- Bone density test to screen for osteoporosis
- Cholesterol and lipid (fat) level
- Colorectal cancer, including fecal occult blood test, barium enema, flexible sigmoidoscopy, screening colonoscopy and related prep kit, and computed tomography (CT) colonography (as appropriate)
- Depression screening
- Hepatitis C virus (HCV) for people at high risk for infection and a one-time screening for adults born between 1945 and 1965
- Type 2 diabetes screening*
- Eye chart test for vision²
- Hearing screening
- Height, weight and body mass index (BMI)
- HIV screening and counseling
- Lung cancer screening for those ages 55-80 who have a history of smoking 30 packs per year and still smoke, or quit within the past 15 years³
- Obesity: related screening and counseling*
- Prostate cancer, including digital rectal exam and prostate-specific antigen (PSA) test
- Sexually transmitted infections: related screening and counseling
- Tobacco use: related screening and behavioral counseling
- Violence, interpersonal and domestic: related screening and counseling

Immunizations:

- Diphtheria, tetanus and pertussis (whooping cough)
- Hepatitis A and hepatitis B
- Human papillomavirus (HPV)
- Influenza (flu)
- Measles, mumps and rubella (MMR)
- Meningococcal (meningitis)
- Pneumococcal (pneumonia)
- Varicella (chickenpox)
- Zoster (shingles)

Women's preventive care:

- Well-woman visits
- Breast cancer, including exam, mammogram, and genetic testing for BRCA 1 and BRCA 2 when certain criteria are met⁴
- Breastfeeding: primary care intervention to promote breastfeeding support, supplies and counseling^{5,6,7}
- Contraceptive (birth control) counseling
- Food and Drug Administration (FDA)-approved contraceptive medical services, including sterilization, provided by a doctor
- Counseling related to chemoprevention for those with a high risk of breast cancer
- Counseling related to genetic testing for those with a family history of ovarian or breast cancer
- HPV screening⁶
- Screening and counseling for interpersonal and domestic violence
- Pregnancy screenings, including gestational diabetes, hepatitis B, asymptomatic bacteriuria, Rh incompatibility, syphilis, HIV and depression⁶
- Pelvic exam and Pap test, including screening for cervical cancer

These preventive care services are recommendations of the Affordable Care Act (ACA or health care reform law). They may not be right for every person, so ask your doctor what's right for you.

This sheet is not a contract or policy with Anthem Blue Cross and Blue Shield. If there is any difference between this sheet and the group policy, the provisions of the group policy will rule. Please see your combined Evidence of Coverage and Disclosure Form or Certificate for exclusions and limitations.

* CDC-recognized Diabetes Prevention programs are available for overweight or obese adults with abnormal blood glucose or who have abnormal CVD risk factors.

Child preventive care

Preventive physical exams

Screening tests:

- Behavioral counseling to promote a healthy diet
- Blood pressure
- Cervical dysplasia screening
- Cholesterol and lipid level
- Depression screening
- Development and behavior screening
- Type 2 diabetes screening
- Hearing screening
- Height, weight and BMI
- Hemoglobin or hematocrit (blood count)
- HPV screening (female)
- Lead testing
- Newborn screening
- Screening and counseling for obesity
- Counseling for those ages 10–24 with fair skin about lowering their risk for skin cancer
- Oral (dental health) assessment when done as part of a preventive care visit
- Screening and counseling for sexually transmitted infections
- Tobacco use: related screening and behavioral counseling
- Vision screening when done as part of a preventive care visit²

Immunizations:

- Chickenpox
- Flu
- Haemophilus influenza type b (Hib)
- Hepatitis A and hepatitis B
- HPV
- Meningitis
- MMR
- Pneumonia
- Polio
- Rotavirus
- Whooping cough

A word about pharmacy items

For 100% coverage of your over-the-counter (OTC) drugs and other pharmacy items listed here, you must:

- Meet certain age requirements and other rules.
- Get prescriptions from plan providers and fill them at plan pharmacies.
- Have prescriptions, even for OTC items.

Child preventive drugs and other pharmacy items — age appropriate:

- Dental fluoride varnish to prevent the tooth decay of primary teeth for children ages 0–5
- Fluoride supplements for children ages 0–6

Adult preventive drugs and other pharmacy items — age appropriate:

- Aspirin use (81 mg and 325 mg) for the prevention of cardiovascular disease, preeclampsia and colorectal cancer by adults less than 60 years old
- Colonoscopy prep kit (generic or OTC only) when prescribed for preventive colon screening
- Tobacco-cessation products, including select generic prescription drugs, select brand-name drugs with no generic alternative and FDA-approved OTC products, for those ages 18 and older
- Vitamin D for adults over age 65

Women's preventive drugs and other pharmacy items — age appropriate:

- Contraceptives, including generic prescription drugs, brand-name drugs with no generic alternative and OTC items like female condoms and spermicides^{6,8,9}
- Low-dose aspirin (81 mg) for pregnant women who are at increased risk of preeclampsia
- Folic acid for women ages 55 or younger who are planning and able to get pregnant
- Breast cancer risk-reducing medications, such as tamoxifen and raloxifene, that follow the U.S. Preventive Services Task Force criteria³

¹ The range of preventive care services covered at no cost share when provided by plan doctors is designed to meet state and federal requirements. The Department of Health and Human Services decided which services to include for full coverage based on U.S. Preventive Services Task Force A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), and certain guidelines for infants, children, adolescents and women supported by Health Resources and Services Administration (HRSA) Guidelines. You may have additional coverage under your insurance policy. To learn more about what your plan covers, see your Certificate of Coverage or call the Member Services number on your ID card.

² Some plans cover additional vision services. Please see your contract or Certificate of Coverage for details.

³ You may be required to get preapproval for these services.

⁴ Check your medical policy for details.

⁵ Breast pumps and supplies must be purchased from plan providers for 100% coverage. We recommend using plan durable medical equipment (DME) suppliers.

⁶ This benefit also applies to those younger than age 19.

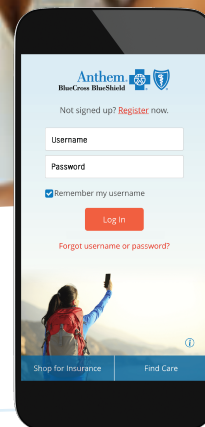
⁷ Counseling services for breastfeeding (lactation) can be provided or supported by a plan doctor or hospital provider, such as a pediatrician, obstetrician/gynecologist or family medicine doctor, and hospitals with no member cost share (deductible, copay, coinsurance). Contact the provider to see if such services are available.

⁸ A cost share may apply for other prescription contraceptives, based on your drug benefits.

⁹ Your cost share may be waived if your doctor decides that using the multisource brand is medically necessary.

You've got quick access to your health care!

Register on [anthem.com](https://www.anthem.com) or the Anthem Anywhere mobile app.*



From your computer



Go to [anthem.com](https://www.anthem.com) and select the  icon above
Already a member? Sign in here.



Provide the personal information requested



Create a username and password



Set your email preferences



Follow the prompts to complete your registration

From your mobile device



Download the free Anthem Anywhere mobile app and select **Register**



Confirm your identity



Create a username and password



Set your email preferences



Follow the prompts to complete your registration



Need help signing up?
Call us at **1-866-755-2680.**

*You must be 18 years or older to register your own account.

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13206ANMENABS VP00 9/16

Looking for a doctor?

Finding one online is fast and easy

Use our online **Find a Doctor** tool to look for doctors, hospitals, labs and other health care providers in your Anthem Blue Cross and Blue Shield plan. Check if your favorite doctor is part of your plan, or look for one near you. Avoid getting care from doctors outside of your plan if you can — it will cost you more or your plan may not cover it all.



Here's all you need to do:

If you're a member


Go to anthem.com, select the member icon  and log in.

Under *Useful Tools* on the right, select **Find a Doctor**.

1

If you're not a member yet

Go to anthem.com.

Select **Menu**  and then choose **Find a Doctor**.



Next, select a type of doctor, place or name.
Select **Search**.

2

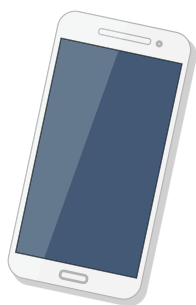
First answer a few questions, so we can help find you the right plan and doctor in your plan. Then enter or select the plan/network*.

Next, select a type of doctor, place or name.
Select **Search**.

3

Select a doctor to see more information, such as:

- Training
- Specialties
- Languages spoken
- Address (including a map)
- Phone number



Going mobile

Use your mobile device to search for doctors, hospitals and more with our free app from the App Store® or Google Play™. Just search for Anthem Anywhere and download the app.

*If you don't know the name of the plan or network, check with your human resources department or benefits administrator.

Anthem Blue Cross and Blue Shield is the trade name of: In Colorado: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. In Connecticut: Anthem Health Plans, Inc. In Georgia: Blue Cross and Blue Shield of Georgia, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): 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. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. Anthem Health Plans of New Hampshire, Inc. HMO plans are administered by Anthem Health Plans of New Hampshire, Inc. and underwritten by Matthew Thornton Health Plan, Inc. In Ohio: Community Insurance Company. In Virginia Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin (BCBSWI), which underwrites or administers the PPO and indemnity policies; CompCare Health Services Insurance Corporation (CompCare), which underwrites or administers the HMO policies; and CompCare and BCBSWI collectively, which underwrite or administer the POS policies. 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.

You have choices

that can save you a lot

Estimate your health care costs and see your options

Sometimes, the cost of health care can be more than what you expect when you need a procedure, service or lab work. But when you know what your cost will be ahead of time, you can plan ahead. With our Estimate Your Cost tool, you can find out costs and compare facilities and providers based on cost and quality ratings for procedures – before you get them. It puts you in control of where and how you spend your health care dollars.

Don't pay too much

Use the Estimate Your Cost tool to **get an idea of what you'll pay** before you get a procedure.

Peace of mind comes when you plan ahead. The Estimate Your Cost tool was designed to help you feel better about where you go for care.

The Estimate Your Cost tool is easy to use

Just follow these steps to get the information you want:

1. Log in to **anthem.com**.

2. Choose **Estimate Your Cost**.

3. Enter the location you want, how far you want to travel and the procedure needed. Then, choose **Search Cost Estimates**.

4. Agree to the Terms of Use and choose **Submit**.

5. Take a look at the list of providers in our network and the estimated costs for the procedure.



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The ABCs on PCPs



Choosing a primary care physician (PCP)

How did you pick your doctor? Did you get advice from friends? Did you choose someone near your home or work? Whether you go to your doctor rarely or often, you should find one you like and trust.

Why do I need a PCP?

You may go to one or more specialists. Still, you should have a PCP for regular things like checkups. There are five main types of PCPs:¹

- **Family practitioners** work with people of all ages. They offer a wide range of care, from checkups to pregnancy care. This type of doctor might be a good choice if you want to keep all of your family “under one roof.” A doctor who treats everyone in a family can get a better view of each person’s health.
- **Pediatricians** specialize in children’s health care. They treat kids from birth to age 18.
- **Internists** mostly work with adults. They offer a range of care, including preventive care. But they may have special knowledge about certain health problems. So if you have a long-term health problem, an internist who focuses on your problem may be a good fit for you.
- **OB/GYN** doctors specialize in the care of women. OB/GYN stands for obstetrician/gynecologist. If you’re a teenage girl or a woman of childbearing age, this type of doctor might be a good choice for you.
- **Nurse practitioners** and **physician assistants** aren’t doctors, but they’ve received a lot of training and can do many of the same things. For instance, they may give shots, do checkups and treat some health problems. They may be the main person you work with, or they may work with a doctor.

Resources

For more tips, visit the Agency for Healthcare Research and Quality online at ahrq.gov. Click on “For Patients & Consumers” then type “Choosing Quality Care” in the search box on the right. You’ll find articles, checklists and more. Plus you can find links to tools that will help you check PCP certifications and quality ratings.



Certain factual or statistical information was derived from the following sources:

1 National Institute on Aging, “Choosing a doctor,” nia.nih.gov updated November 2009, accessed December 2011.

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At home or on the go, doctors and mental health professionals are here for you.

Starting 1/1/2018 you can also meet with board-certified Psychiatrists using LiveHealth Online!



When you're not feeling well you can get the support you need easily using LiveHealth Online. Whether you have a cold, you're feeling anxious or need help managing your medication, doctors and mental health professionals are right there, ready to help you feel your best. Using LiveHealth Online you can have a video visit with a board-certified doctor, psychiatrist or licensed therapist from your smartphone, tablet or computer from home or anywhere.

You've got access to affordable and convenient care

Your Anthem plan includes benefits for video visits using LiveHealth Online, so you'll just pay your share of the costs — usually \$49 or less for medical doctor visits, and a 45-minute therapy or psychiatry session usually costs the same as an office visit.

On LiveHealth Online, you can:

- **See a board-certified doctor 24/7.** You don't need an appointment to see a doctor. They're always available to assess your condition and send a prescription to the pharmacy you choose, if needed.¹ It's a great option when you have pink eye, a cold, the flu, a fever, allergies, a sinus infection or another common health issue.
- **Visit a licensed therapist in four days or less.**² Have a video visit with a therapist to get help with anxiety, depression, grief, panic attacks and more. Schedule your appointment online or call **1-888-548-3432** seven days a week.
- **Consult a board-certified psychiatrist within two weeks.**³ If you're over 18 years old, you can get medication support to help you manage a mental health condition. To schedule your appointment call **1-888-548-3432** seven days a week.

Sign up for LiveHealth Online today – it's quick and easy

Go to livehealthonline.com or download the app and register on your phone or tablet.



1 Prescription availability is defined by physician judgment and state regulations. Visit the home page of livehealthonline.com to view the service map by state.

2 Appointments subject to availability of a therapist.

3 Prescriptions determined to be a "controlled substance" (as defined by the Controlled Substances Act under federal law) cannot be prescribed using LiveHealth Online. Psychiatrists on LiveHealth Online will not offer counseling or talk therapy. Appointments subject to availability.

Online counseling is not appropriate for all kinds of problems. If you are in crisis or have suicidal thoughts, it's important that you seek help immediately. Please call 1-800-784-2433 (National Suicide Prevention Lifeline) or 911 and ask for help. If your issue is an emergency, call 911 or go to your nearest emergency room. LiveHealth Online does not offer emergency services.

If you're a retiree or have coverage that complements your Medicare benefits, your employer sponsored health plan may not include coverage for online visits using LiveHealth Online. Check your plan documents for details. You can still use LiveHealth Online, but you may have to pay the full cost of a visit. Online visits using LiveHealth Online may not be a covered benefit for HRA and HIA+ members.

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Frequently asked questions

What is LiveHealth Online?

With LiveHealth Online, you have a doctor by your side 24/7 when your own doctor isn't available. LiveHealth Online lets you talk to a board-certified doctor through two-way live video from your mobile device, tablet or a computer with a webcam. Use LiveHealth Online for common health concerns like colds, the flu, fevers, rashes, infections and allergies. It's fast, easy and convenient.

Why would I use LiveHealth Online instead of going to visit my doctor in person?

LiveHealth Online is not meant to replace your primary care doctor. However, it is a convenient option for care if your doctor is not available, you are traveling on business or you need quick care for common problems like a cold or the flu. LiveHealth Online connects you with a board-certified doctor in just a few minutes. Plus, you can get a LiveHealth Online visit summary from the MyHealth tab on anthem.com to print, email or fax to your primary doctor.

LiveHealth Online should not be used for emergency care. If you experience a medical emergency, call 911 immediately.

When is LiveHealth Online available?

Doctors are available on LiveHealth Online seven days a week, 24 hours a day.

How do I access the LiveHealth Online mobile app?

You can download the LiveHealth Online mobile app for free:



Get the free LiveHealth Online app today from Google Play[™] or the App StoreSM

Do doctors have access to my health information?

LiveHealth Online doctors can only access your health information and treatment recommendations from prior LiveHealth Online visits. If you are using LiveHealth Online for the first time, you will be asked to answer a brief questionnaire about your health before you speak with a doctor. Then the information from your first online visit and all subsequent visits will be available for future LiveHealth Online visits.

How does LiveHealth Online work?

When you need to talk to a doctor, simply go to livehealthonline.com or access the LiveHealth Online mobile app. Select the state you are located in and answer a few questions. LiveHealth Online may already be a part of your health plan, so your visit may cost the same as a primary care office visit copay or \$49, depending on your health plan benefits. Establishing an account allows you to securely store your personal and health information for common health concerns. Plus, you can easily connect with doctors in the future, share your health history and schedule online visits at times that fit your schedule.

How long does a LiveHealth Online session with a doctor usually last?

A typical LiveHealth Online session lasts about 10 minutes.

How much does it cost to use LiveHealth Online?

LiveHealth Online may be a part of your health plan. So your visit may cost the same as a primary care office visit copay or \$49, depending on your medical plan benefits. To find out how much your visit will cost, enter your member ID on LiveHealth Online and the cost will be shown before you visit with a doctor. If you're an Anthem Blue Cross and Blue Shield (Anthem) member and LiveHealth Online is a covered benefit, your claim will be submitted automatically. You, your family and friends who are not Anthem members also can use LiveHealth Online by paying the full cost of the visit — \$49.

Will I be charged more if I use LiveHealth Online on weekends, holidays or at night?

No, the cost is the same.

How do I pay for a LiveHealth Online session?

LiveHealth Online accepts Visa, MasterCard and Discover cards as payment for an online visit with a doctor. Please keep in mind that charges for prescriptions aren't included in the cost of your doctor visit.

Can I get online care from a doctor if I'm traveling or in another state?

As long as you are located in a state where LiveHealth Online is available, you can get online care. To determine which states have online doctor visits available, please visit the map at livehealthonline.com and view the state map at the bottom of the home page.

Why do some states offer prescriptions after my visit and other states don't?

Some state laws require a face-to-face visit before allowing prescriptions.* Each state is different and these laws change often. To determine which states have prescription availability online, please visit livehealthonline.com and view the state map at the bottom of the home page. Doctors using LiveHealth Online are not able to prescribe controlled substances or lifestyle drugs.

Do I have what I need to access doctors through LiveHealth Online?

To find out how to use LiveHealth Online on your computer, tablet or mobile device, go to livehealthonline.com and select the **About** tab and scroll down to the *More Information* section on the left side of the page.

Who do I get in touch with if I still have questions?

You can email customersupport@livehealthonline.com or call toll free at 1-855-603-7985. If you send us an email, please be sure to include the following:

- Your name
- Your email address
- A phone number where you can be reached



* Prescription availability is defined by physician judgment and state regulations. LiveHealth Online is available in most states and is expected to expand to more in the near future. Visit the home page of livehealthonline.com to view the service map by state.

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Live life to the fullest – without paying full price



Save money with discounts at anthem.com

Saving money is good. Saving money on things that are good for you – that's even better. With SpecialOffers, you can get discounts on products and services that help promote better health and well-being.* It's just one of the perks of being a member. Check out how much you can save:

Vision and hearing

1-800 CONTACTS® — Get contact lenses quick and easy — plus discounts only available to Anthem members, like \$20 off when you spend \$100 or more and free shipping.

Glasses.com™ — Get the latest, brand-name frames for just a fraction of the cost at typical retailers — every day. Plus, you get an additional \$20 off orders of \$100 or more, free shipping and free returns.

Premier LASIK — Save 15% on LASIK with all in-network providers. Prices are as low as \$695 per eye with select providers.

Amplifon — Get a low-price guarantee with the seven top companies that work with Amplifon. Save \$50 on one hearing aid or \$125 on two. Plus, get a three-year repair/loss/damage warranty and a free two-year supply of batteries.

Beltone™ — Get hearing screenings and in-home service at no additional cost, and up to 50% off all Beltone hearing aids.

Fitness and health

Jenny Craig® — Join Jenny Craig and obtain 50% off All Access Enrollment plus 5% off all Jenny Craig Food.

Lindora® — Save 20% on weight-loss programs.

SelfHelpWorks — Choose one of the online Living programs and get a 40% discount to help you lose weight, stop smoking, manage stress or face an alcohol problem.

GlobalFit™ — Save on gym memberships and GlobalFit's Virtual Gym.

ChooseHealthy™ — Get preferred pricing on fitness club memberships and a one-week free trial. Enjoy discounts on acupuncture, chiropractors and massage — plus 40% off certain wellness products.

Performance Bicycle — Get \$20 off a purchase of \$80 or more in store or online.

Garmin — Save 20% on the vivofit 2, vivosmart, vivoactive, or Forerunner 15 wearable activity trackers.



Special Offers on anthem.com

Family and home

Safe Beginnings® — Babyproof your home while saving 15% on everything from safety gates to outlet covers.

VPI Pet Insurance — Get 5% off pet insurance. Get peace of mind knowing that you have help paying the medical costs for your pet's accidents, illnesses and routine medical care.

ASPCA Pet Health Insurance — Get 5% off pet insurance. You can choose from three levels of care, including flexible deductibles and custom reimbursements.

LinkWell — Get coupons for healthier products.

WINFertility® — Save up to 40% on infertility treatment. WINFertility helps make quality treatment affordable.

LifeMart® — Get great deals on beauty and skin care, diet plans, fitness club memberships and plans, personal care, spa services and yoga classes, sports gear and vision care.

HelpCare Plus — Get discounts on Senior Care Services by paying \$11.25 per month. You even get a pharmacy discount card.

Medicine and treatment

Puritan's Pride — Save 10% and get free shipping on a large selection of vitamins, minerals, herbs, supplements and much more.

Allergy Control products — Save 25% on Allergy Control encasings for your bed. Plus, save 20% on a variety of doctor-recommended products for a healthier home and enjoy free shipping on orders of \$150 or more.

National Allergy® supply — Save 15% on mattress encasings, air filtration products, compressors and other products that can help relieve your allergy, asthma and sinus symptoms.

To find the discounts that are available to you, log in to [anthem.com](https://www.anthem.com) and select **Discounts**.



* All discounts are subject to change without notice.

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

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Choose an easier way to better health

Health and wellness programs designed for your unique needs

Whether you're suffering from asthma, expecting a baby or just fighting a cold, our health and wellness programs can help.



ConditionCare

If you have asthma, diabetes, chronic obstructive pulmonary disease (COPD), heart disease or heart failure, ConditionCare can give you the tools and resources you need to take charge of your health. You'll get:

- 24/7, toll-free phone access to nurses who can answer health questions.
- Support from nurse care managers, dietitians and other health care professionals to help you reach your health goals.
- Educational guides, electronic newsletters and tools to help you learn more about your condition(s).



Future Moms

Having a baby is an exciting time! Future Moms can help you have a healthy pregnancy and a healthy baby. Sign up as soon as you know you're pregnant. You'll get:

- A nurse specializing in obstetrics who can answer your questions, 24/7, and will call to check on your progress.
- The *Mayo Clinic Guide to a Healthy Pregnancy*, which explains the changes your body and baby are going through.
- A screening to check your health risks.
- Resources to help you make healthier decisions during pregnancy.
- Free phone access to pharmacists, nutritionists and other specialists, if needed.
- Other helpful information on labor and delivery, including options and how to prepare.



24/7 NurseLine

Whether it's 3 a.m. or a lazy Sunday afternoon, you can talk to a registered nurse any time of the day or night.

These nurses can:

- Answer questions about health concerns.
- Help you decide where to go for care when your doctor isn't available.
- Help you find providers and specialists in your area.
- Enroll you and your dependents in health management programs.
- Remind you about scheduling important screenings, exams and checkups.

Get the support you need

Call us to sign up and use these programs at no extra cost:

- ConditionCare: 866-962-0959
- Future Moms: 800-828-5891
- 24/7 NurseLine: 800-337-4770





Let's talk about your privacy and rights

Safeguarding your information

As a member, you have the right to expect us to protect the privacy of your personal health information. We do this according to state and federal laws, and our policies. You also have certain rights and responsibilities when receiving your health care.

To learn more about how we protect your privacy, your rights and responsibilities when receiving health care and your rights under the Women's Health and Cancer Rights Act, go to www.anthem.com/memberrights. To ask for a printed copy, please contact your Benefits Administrator or Human Resources representative.

How we help manage your care

To decide if we'll cover a treatment, procedure or hospital stay, we use a process called Utilization Management (UM). Doctors and pharmacists who want to be sure you get the best treatments for certain health conditions make up Anthem's UM team. They review the information your doctor sends us. These reviews can be done before, during or after your treatment. We also use case managers. They're licensed health care professionals who work with you and your doctor to help you learn about and manage your health conditions. They also help you better understand your health benefits.

To learn more detailed information about how we help manage your care, visit www.anthem.com/memberrights. To request a printed copy, please contact your Benefits Administrator or Human Resources representative.



This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.



We've got your back!



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