Our plans fit your plans

HealthChoice®
HealthChoice® Standard
HealthChoice® Basic
Our plans fit the way you live.

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

For over 70 years, Anthem Blue Cross and Blue Shield has provided health care coverage and security to our Maine neighbors. And now, we’re pleased to offer these same Individual health care plans with added benefits and features of the Patient Protection and Affordable Health Care Act.

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

Sounds like a plan.

Experience you can rely on

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

- One of the largest provider networks in Maine. With more than 3,000 doctors and specialists and 40 hospitals* throughout the state, chances are your doctor is in one of our networks.
- A choice of plans to help fit your budget and lifestyle. No matter where you are in life, we’ve got a plan designed to help fit your health coverage needs, as well as your budget.
- Coverage that travels with you. No matter where life takes you, your health coverage goes with you. And network providers in the BlueCard® program across the country will help make it easy to get access to the care you need.

Why do you need health care coverage?

These days, a single day in the hospital can cost thousands of dollars. The financial risk you take without health coverage just isn’t worth it. Not only does health care coverage help you stay healthy, it also gives you added security, because you know you’re protected against the high cost of unexpected medical bills.

*BCBSA Provider Data Counts 2010
Some definitions so we’re all on the same page

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

This is true whether you are paying the entire cost for covered services (such as while you are meeting your deductible), or whether we are sharing the cost. With over 3,000 doctors and specialists and 40 hospitals and other facilities, chances are your provider already participates. Just visit a network provider to take advantage of the savings.

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

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

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

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

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

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

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

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

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

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

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

**Formulary** is a list of prescription drugs our health care plans cover. They include generic and preferred brand name drugs that have been rigorously reviewed and selected by a committee of practicing doctors and clinical pharmacists for their quality and effectiveness. We’ve negotiated lower prices on these formulary drugs, so you’ll save when your doctor prescribes medication from our formularies. There can be different formularies for different health care plans. Formulary lists can be found at anthem.com.
Read your policy carefully – this outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract, and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is therefore important that upon enrollment, you **READ YOUR POLICY CAREFULLY!**

HealthChoice coverage is designed to provide coverage for major hospital, medical and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, out-of-hospital care, and prescription drugs, subject to any deductibles, copayment provisions, or other limitations that may be set forth in this policy.

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<td><strong>We begin paying benefits for most covered services after the deductible has been met.</strong> Covered services are paid at a percentage of our Maximum Allowance until the coinsurance limit is met—then 100% <em>(unless otherwise stated).</em> Limits are per person per calendar year <em>(unless otherwise stated).</em></td>
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<tr>
<td>1. Individual Deductible*</td>
<td>$2,250, $5,000</td>
<td>$250, $500, $1,000 or $1,500</td>
<td>$250, $500, $1,000 or $1,500</td>
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<tr>
<td>2. Family Deductible*</td>
<td>The family deductible limit is twice the individual deductible amount and applies to policies that have 2 or more members.</td>
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<td>3. Coinsurance*</td>
<td>You pay no coinsurance on medical services after your deductible has been met.</td>
<td>You pay 20% after your deductible has been met.</td>
<td>You pay 40% after your deductible has been met.</td>
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<tr>
<td>4. Individual Coinsurance Limit*</td>
<td>HealthChoice pays 100% on medical services.</td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
<tr>
<td>5. Family Coinsurance Limit*</td>
<td>HealthChoice pays 100% on medical services.</td>
<td>The family coinsurance limit is twice the individual coinsurance limit. All family members combine their coinsurance payments until the family coinsurance limit is met. One family member may not meet the family coinsurance.</td>
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<td>6. Lifetime Maximum Benefit</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
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* See Definitions of Terms on previous page.
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<tr>
<th>Benefits</th>
<th>HealthChoice Standard</th>
<th>HealthChoice Basic</th>
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<tr>
<td><strong>7. Hospital and Other Provider Services</strong>&lt;br&gt;(You must call 1-800-392-1016 for preauthorization of all non-emergency and non-maternity inpatient admissions. For emergency and maternity admissions you should call within 48 hours.)</td>
<td>100%&lt;br&gt;(limited to 365 days per stay)</td>
<td>80%&lt;br&gt;(limited to 60 days per calendar year)</td>
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<tr>
<td><strong>8. Physician and Professional Services</strong>&lt;br&gt;(Medical and Surgical)</td>
<td>100%</td>
<td>80%&lt;br&gt;(limited to 60 days per calendar year)</td>
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<tr>
<td><strong>9. Emergency Care</strong></td>
<td>Emergency Room&lt;br&gt;100%</td>
<td>$50 copayment if NOT admitted to the hospital&lt;br&gt;(No deductible or coinsurance)&lt;br&gt;$75 copayment if NOT admitted to the hospital&lt;br&gt;(No deductible or coinsurance)</td>
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<td>Doctor’s office&lt;br&gt;100%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>10. Diagnostic</strong></td>
<td>Hospital&lt;br&gt;100%</td>
<td>80%</td>
</tr>
<tr>
<td></td>
<td>Doctor’s office&lt;br&gt;100%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>11. Physical Manipulations/Adjustments</strong></td>
<td>100%&lt;br&gt;(limited to 25 manipulations, per calendar year)</td>
<td>80%&lt;br&gt;(limited to 36 visits, per calendar year)</td>
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<td><strong>12. Mental Health Services</strong>&lt;br&gt;<strong>Note:</strong> Additional coverage may be purchased for domestic partners who meet certain criteria. An affidavit of domestic partnership must be completed prior to enrollment.</td>
<td>Inpatient&lt;br&gt;You must call 800-755-0851 for pre-authorization of all non-emergency inpatient care&lt;br&gt;80%&lt;br&gt;(limited to 31 days, per calendar year)</td>
<td>80%&lt;br&gt;(limited to 30 days, per calendar year)</td>
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<td></td>
<td>Outpatient&lt;br&gt;50%&lt;br&gt;(limited to 25 visits, per calendar year)</td>
<td>50%</td>
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<tr>
<td><strong>13. Prescription Drugs</strong></td>
<td>100%</td>
<td>80%</td>
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**Note:** Additional coverage may be purchased to cover the treatment of a listed illness paid at the same level as a physical illness. Please contact your agent or an Anthem Blue Cross and Blue Shield representative for further details and rates.
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<tr>
<td>14. Ambulance</td>
<td>100%</td>
<td>80%</td>
<td>60%</td>
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<tr>
<td>15. Home Health Care</td>
<td>100%</td>
<td>80%</td>
<td>60%</td>
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<tr>
<td></td>
<td>(limited to 90 visits, per calendar year)</td>
<td>(limited to 100 visits, per calendar year)</td>
<td>(limited to 100 visits, per calendar year)</td>
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<tr>
<td>16. Hospice Care</td>
<td>100%</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>17. Skilled Nursing Facility</td>
<td>100%</td>
<td>80%</td>
<td>NOT Covered</td>
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<tr>
<td></td>
<td>(limited to 365 days, per calendar year)</td>
<td>(limited to 100 days, per calendar year)</td>
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<tr>
<td>18. Physical, Occupational and Speech Therapy</td>
<td>100%</td>
<td>80%</td>
<td>60%</td>
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<td></td>
<td>(combined limit of 24 visits per calendar year)</td>
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<tr>
<td>19. Substance Abuse Services</td>
<td>Inpatient</td>
<td>80%</td>
<td>80%</td>
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<td></td>
<td>(You must call 1-800-755-0851 for pre-authorization of all non-emergency inpatient care)</td>
<td>(limited to 31 days, per calendar year)</td>
<td>(limited to 30 days, per calendar year and 60 days during lifetime)</td>
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<tr>
<td></td>
<td>Outpatient</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>(limited to 25 visits, per calendar year)</td>
<td></td>
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<tr>
<td>20. Preventive Care</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
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<tr>
<td>Covers all nationally recommended preventive care services, including well-child care, immunizations, PSA screenings, Pap tests, mammograms, and more.</td>
<td>(not subject to deductible)</td>
<td>(not subject to deductible)</td>
<td>(not subject to deductible)</td>
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<tr>
<td>21. Maternity</td>
<td>100%</td>
<td>80%</td>
<td>60%</td>
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For applicants age nineteen and older, Anthem Blue Cross and Blue Shield will not provide benefits for 12 months from the date of application for a pre-existing condition or for complications or treatment arising from a pre-existing condition for any member without qualifying health insurance coverage within the 90 days preceding the date of application. Benefits are available as described in our certificate.

This chart is only a comparison of the different benefits offered by HealthChoice, HealthChoice Standard and HealthChoice Basic. The certificate of coverage you will receive fully describes the benefits and exclusions. In the event of a conflict between the certificate and this chart, the terms of the certificate will prevail. The following are examples of services NOT covered by HealthChoice, HealthChoice Standard and HealthChoice Basic: Cosmetic Services, Custodial Care, Genetic Testing, Hearing Aids for adults 18 and older, Refractive Eye Surgery, Services After Your Contract Ends, Services Before the Effective Date, Sex Changes, Temporomandibular Joint (TMJ) Syndrome Services, Travel Expenses, Vision Therapy, Workers’ Compensation. Please read your certificate carefully.

**Utilization Management and Case Management**

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

**Prospective Review / Pre-Admission Review**

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

- inpatient hospitalizations
- outpatient procedures
- diagnostic procedures
- therapy services
- durable medical equipment

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

**Concurrent Review**

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

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

**Retrospective Review**

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

**Case Management**

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

We are committed to:

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

You have the right to:

- Participate with your health care professionals and providers in making decisions about your health care.
- Receive the benefits for which you have coverage.
- Be treated with respect and dignity.
- Privacy of your personal health information, consistent with state and federal laws, and our policies.
- Receive information about our organization and services, our network of health care professionals and providers, and your rights and responsibilities.
- Candidly discuss with your physicians and providers appropriate or medically necessary care for your condition, regardless of cost or benefit coverage.
- Make recommendations regarding the organization’s members’ rights and responsibilities policies.
- Voice complaints or appeals about: our organization, any benefit or coverage decisions we (or our designated administrators) make, your coverage, or care provided.
- Refuse treatment for any condition, illness or disease without jeopardizing future treatment, and be informed by your physician(s) of the medical consequences.
- Participate in matters of the organization’s policy and operations.
- For assistance at any time, contact your local insurance department:
  MAINE
  Phone: (800) 300-5000
  Write: Bureau of Insurance Department of Professional and Financial Regulation
  #34 State House Station
  Augusta, ME 04333-0034

You have the responsibility to:

- Choose a participating primary care physician if required by your health benefit plan.
- Treat all health care professionals and staff with courtesy and respect.
- Keep scheduled appointments with your doctor, and call the doctor’s office if you have a delay or cancellation.
- Read and understand to the best of your ability all materials concerning your health benefits or ask for help if you need it.
- Understand your health problems and participate, along with your health care professionals and providers in developing mutually agreed upon treatment goals to the degree possible.
- Supply, to the extent possible, information that we and/or your health care professionals and providers need in order to provide care.
- Follow the plans and instructions for care that you have agreed on with your health care professional and provider.
- Tell your health care professional and provider if you do not understand your treatment plan or what is expected of you.
- Follow all health benefit plan guidelines, provisions, policies and procedures.
- Let our Customer Service Department know if you have any changes to your name, address, or family members covered under your policy.
- Provide us with accurate and complete information needed to administer your health benefit plan, including other health benefit coverage and other insurance benefits you may have in addition to your coverage with us.

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

We keep the health and financial information of our current and former members private as required by law, accreditation standards, and our rules. This notice explains your rights. It also explains our legal duties and privacy practices. We are required by federal law to give you this notice.

Your Protected Health Information

We may collect, use, and share your Protected Health Information (PHI) for the following reasons and others as allowed or required by law, including the HIPAA Privacy rule:

For Payment: We use and share PHI to manage your account or benefits; or to pay claims for health care you get through your plan. For example, we keep information about your premium and deductible payments. We may give information to a doctor’s office to confirm your benefits.

For Health Care Operations: We use and share PHI for our health care operations. For example, we may use PHI to review the quality of care and services you get. We may also use PHI to provide you with case management or care coordination services for conditions like asthma, diabetes, or traumatic Injury.

For Treatment Activities: We do not provide treatment. This is the role of a health care provider such as your doctor or a hospital. But, we may share PHI with your health care provider so that the provider may treat you.

To You: We must give you access to your own PHI. We may also contact you to let you know about treatment options or other health-related benefits and services. When you or your dependents reach a certain age, we may tell you about other products or programs for which you may be eligible. This may include individual coverage. We may also send you reminders about routine medical checkups and tests.

To Others: You may tell us in writing that it is OK for us to give your PHI to someone else for any reason. Also, If you are present, and tell us it is OK, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are not present, if it is an emergency, or you are not able to tell us it is OK, we may give your PHI to a family member, friend or other person if sharing your PHI is in your best interest.

As Allowed or Required by Law: We may also share your PHI, as allowed by federal law, for many types of activities. PHI can be shared for health oversight activities. It can also be shared for judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and to coroners, funeral directors or medical examiners (about decedents). PHI can also be shared for certain reasons with organ donation groups, for research, and to avoid a serious threat to health or safety. It can be shared for special government functions, for workers compensation, to respond to requests from the U.S. Department of Health and Human Services and to alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or other crimes. PHI can also be shared as required by law.

If you are enrolled with us through an employer sponsored group health plan, we may share PHI with your group health plan. We and/or your group health plan may share PHI with the sponsor of the plan. Plan sponsors that receive PHI are required by law to have controls in place to keep it from being used for reasons that are not proper.

Authorization: We will get an OK from you in writing before we use or share your PHI for any other purpose not stated in this notice. You may take away this OK at any time, in writing. We will then stop using your PHI for that purpose. But, if we have already used or shared your PHI based on your OK, we cannot undo any actions we took before you told us to stop.

Your Rights

Under federal law, you have the right to:

• Send us a written request to see or get a copy of certain PHI or ask that we correct your PHI that you believe is missing or incorrect. If someone else (such as your doctor) gave us the PHI, we will let you know so you can ask them to correct it.
• Send us a written request to ask us not to use your PHI for treatment, payment or health care operations activities. We are not required to agree to these requests.
• Give us a verbal or written request to ask us to send your PHI using other means that are reasonable. Also let us know if you want us to send your PHI to an address other than your home if sending it to your home could place you in danger.
• Send us a written request to ask us for a list of certain disclosures of your PHI.
Call Customer Service at the phone number printed on your identification (ID) card to use any of these rights. They can give you the address to send the request. They can also give you any forms we have that may help you with this process.

**How We Protect Information**

We are dedicated to protecting your PHI. We set up a number of policies and practices to help make sure your PHI is kept secure.

We keep your oral, written, and electronic PHI safe using physical, electronic, and procedural means. These safeguards follow federal and state laws. Some of the ways we keep your PHI safe include offices that are kept secure, computers that need passwords, and locked storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. The policies limit access to PHI to only those employees who need the data to do their job. Employees are also required to wear ID badges to help keep people who do not belong, out of areas where sensitive data is kept. Also, where required by law, our affiliates and non-affiliates must protect the privacy of data we share in the normal course of business. They are not allowed to give PHI to others without your written OK, except as allowed by law.

**Potential Impact of Other Applicable Laws**

HIPAA (the federal privacy law) generally does not preempt, or override other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to provide you with more privacy protections, then we must also follow that law in addition to HIPAA.

**Complaints**

If you think we have not protected your privacy, you can file a complaint with us. You may also file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services. We will not take action against you for filing a complaint.

**Contact information**

Please call Customer Service at the phone number printed on your ID card. They can help you apply your rights, file a complaint, or talk with you about privacy issues.

**Copies and Changes**

You have the right to get a new copy of this notice at any time. Even if you have agreed to get this notice by electronic means, you still have the right to a paper copy. We reserve the right to change this notice. A revised notice will apply to PHI we already have about you as well as any PHI we may get in the future. We are required by law to follow the privacy notice that is in effect at this time. We may tell you about any changes to our notice in a number of ways. We may tell you about the changes in a member newsletter or post them on our web site. We may also mail you a letter that tells you about any changes.

**State Notice Of Privacy Practices**

As we told you in our HIPAA notice, we must follow state laws that are more strict than the federal HIPAA privacy law. This notice explains your rights and our legal duties under state law.

**Your Personal Information**

- We may collect, use and share your non-public personal information (PI) as described in this notice. PI identifies a person and is often gathered in an insurance matter. PI could also be used to make judgments about your health, finances, character, habits, hobbies, reputation, career, and credit.
- We may collect PI about you from other persons or entities such as doctors, hospitals, or other carriers.
- We may share PI with persons or entities outside of our company without your OK in some cases.
- If we take part in an activity that would require us to give you a chance to opt-out, we will contact you. We will tell you how you can let us know that you do not want us to use or share your PI for a given activity.
- You have the right to access and correct your PI.
- We take reasonable safety measures to protect the PI we have about you.

A more detailed state notice is available upon request. Please call the phone number printed on your ID card.
Individual health coverage.
Your plans. Your choices.

Make sure you have all the facts.

This brochure is only one piece of your plan information. Please make sure you have all the facts about the benefits offered by the plan[s] described — including what’s covered, and what isn’t. For additional information about this coverage please see the Coverage Details. This document should be included with your information kit, or if you have printed this brochure from your computer, it should be at the end. If you did not receive a copy of the Coverage Details, be sure to contact your Anthem agent.

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

This summary of benefits complies with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits.

We want you to be satisfied.

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

Ready to enroll?

Call your Anthem agent today!

In Maine, Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Maine, Inc., an independent licensee of the Blue Cross and Blue Shield Association. ® Registered marks of the Blue Cross and Blue Shield Association.