



Health. Join In.

Individual and Family Health Care Plans
for **Wisconsin**

Our plans fit your plans



Premier



Our plans fit the way you live.

In a world that's constantly changing, one thing's for certain. You can benefit from the reliability and protection of health care coverage. Whether you're self-employed, need coverage for your family, just left group coverage, or your job doesn't provide it, Anthem Blue Cross and Blue Shield offers dependable individual health care plans that save you time and make sense for the way you live.

You're in charge of your health and budget, and our plans help keep it that way. Check out our wide range of benefit options and if you have any questions, we are here to help. Dependable, valuable protection that fits the way you live. Sounds like a plan.

Experience you can rely on

As one of the most trusted names in health coverage, Anthem has been providing health care coverage and security to Wisconsin for over 65 years. We're committed to helping simplify your life and improving your health. In addition, we offer:

- **One of the largest provider networks in Wisconsin.** With more than 11,800 doctors and specialists and nearly 150 hospitals throughout the state, chances are your doctor is in one of our networks.
- **A choice of plans to fit your budget and lifestyle.** No matter where you are in life, we've got a plan designed to fit your health coverage needs, as well as your budget.
- **Optional dental and life insurance.** To enhance your health, we also offer dental and term life coverage and make it easy to enroll.
- **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.

Save on the cost of your coverage with the Blue Preferred Plus® POS Network

Anthem offers a choice of provider networks: Blue Access® (PPO) and Blue Preferred Plus® (POS). The Blue Preferred Plus POS® network offers a lower premium with the same flexibility as our PPO network. Like the Blue Access® network, you are not required to choose a PCP or to obtain referrals. Plus, you have the same access to network providers nationally and worldwide through the BlueCard® program. To find a Blue Preferred Plus® POS provider, go to anthem.com >> "Find a Doctor". Then select Blue Preferred Plus® (POS) and "Select a plan or network".

Some definitions so we're all on the same page

Network Discounts: With Anthem, you have access to one of the largest provider networks in the state. These network (or participating) providers have agreed to accept lower costs for their covered services to Anthem members — similar to volume discounts. These negotiated costs help 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 11,800 doctors and specialists and nearly 150 hospitals and other facilities, chances are your provider already participates. Just visit a network provider to take advantage of the savings.

With our PPO and POS 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 care coverage. The level of cost-sharing you choose directly impacts your premium amount. The more you are willing to share in the costs, the lower your premium. With Anthem, you can choose your level of protection and the level of cost-sharing that works best for your health care needs and budget.

Deductible is the amount you have to pay each calendar year (annually) for covered services before your health care plan starts paying. For some services, the plan will even begin to pay before the deductible is met. 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 services for the rest of the calendar year.

Lifetime Maximum is the lifetime benefit amount that will be paid under the policy for each member. This includes network and non-network covered services combined.

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:** Generally includes generic drugs and a few lower cost brand name drugs.
- **Tier 2:** Generally includes higher cost generic and brand name drugs.
- **Tier 3 and 4:** 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.

Health Savings Account (HSA) is a special bank account that can be set up by a member enrolled in a qualified HSA-compatible high deductible health plan. Contributions to this account can be made with certain tax advantages and funds from the account can be used for qualified health care expenses. See the insert from our preferred banking partner for more details and consult your tax advisor.

Premier Is this the right plan for you?

Premier health plans offer the highest level of benefits we offer for a variety of services. Great for families or for individuals looking for richer benefits, Premier offers the most benefits before the deductible of any plan we offer and richer coverage as well as for preventive care and prescription drugs.

Premier Plan Highlights

Premier offers robust benefits for both routine and unexpected medical care. The lowest levels of coinsurance across all deductibles gives Premier added value over other plans we offer.

Features:

- Premier offers options with an unlimited number of Doctors' Office Visits, with predictable copayment, before the deductible.
- Offers a choice of prescription drug coverage options.
- Preventive care benefits help focus on keeping you healthy.
- \$7 million per member in lifetime benefits.

You should know:

- Maternity benefits are available with this plan at an additional cost.
- Premier has our highest level of benefits available, so the premiums are typically more than our other plans.

Premier Preventive Care

Preventive care is an important component of Premier plan coverage. You receive covered preventive services before the deductible, including childhood immunizations, mammograms, Pap and PSA tests and more! See your Benefit Guide for more details.

Prescription Drug Coverage

Premier offers broad prescription drug coverage, including benefits for generic and brand name drugs. There is a separate deductible for brand name drugs.

You also have the choice to upgrade your prescription drug coverage to remove the separate deductible and have more predictable cost-sharing amounts.

See your Benefit Guide for more details.

How to Customize your Premier Plan

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

Deductible: Premier deductibles range from \$500 to \$10,000. You can usually lower your premium by choosing a higher deductible. Simply choose the deductible and premium combination that works best for you.

Coinsurance: At certain deductible levels, you have a choice of a percentage coinsurance or no coinsurance at all for most care and coverage at 100% after satisfying your deductible. The zero coinsurance options will increase your levels of coverage but also your premium if you choose it.

Doctors' Office Copayment: You can lower your monthly premium cost by choosing to remove the doctors' office copayment and instead apply those visits to your policy deductible. After your deductible is met, you would pay a coinsurance amount for doctor office visits if you choose this option.

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

Benefits Premier POS and PPO

Calendar Year Deductible		Your Choices						
Individual	NETWORK:	\$500	\$1,000	\$1,500	\$2,500	\$3,500	\$5,000	\$10,000
	NON-NETWORK:	\$500	\$1,000	\$1,500	\$2,500	\$3,500	\$5,000	\$10,000
Family	NETWORK:	\$1,000	\$2,000	\$3,000	\$5,000	\$7,000	\$10,000	\$20,000
	NON-NETWORK:	\$1,000	\$2,000	\$3,000	\$5,000	\$7,000	\$10,000	\$20,000

Network Coinsurance Options	20%	20%	20%	0% or 20%	0%	0%	0%
-----------------------------	-----	-----	-----	-----------	----	----	----

Calendar Year Out-of-Pocket Maximum		Add Your Chosen Deductible to the Amount Below						
Individual	NETWORK:	\$2,500	\$2,500	\$2,500	\$0 or \$2,500	\$0	\$0	\$0
	NON-NETWORK:	\$7,500	\$7,500	\$7,500	\$7,500	\$7,500	\$7,500	\$7,500
Family	NETWORK:	\$5,000	\$5,000	\$5,000	\$0 or \$5,000	\$0	\$0	\$0
	NON-NETWORK:	\$15,000	\$15,000	\$15,000	\$15,000	\$15,000	\$15,000	\$15,000

How family deductibles and family out-of-pocket maximums work: Each family member has an individual deductible and out-of-pocket maximum. The family deductible and out-of-pocket maximum can be satisfied by 2 or more members. No one person can contribute more than their individual deductible or out-of-pocket maximum.

Plan Lifetime Maximum: Plan pays up to: \$7 million per member, network and non-network services combined

Covered Services Your Share of Costs (after deductible, unless waived)

Doctors' Office Visits	<p>NETWORK: Office Visits \$30 Copayment, deductible waived, for primary care physician; \$40 Copayment, deductible waived, for specialist; No Office Copayment Option (available on \$1,500/20% and \$2,500/0%) Office visits 20% or 0% Coinsurance¹; Other Services (for all plan deductibles) 20% or 0% Coinsurance¹</p> <p>NON-NETWORK: 40% or 30% Coinsurance¹</p>
Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.)	<p>NETWORK: 20% or 0% Coinsurance¹</p> <p>NON-NETWORK: 40% or 30% Coinsurance¹</p>
Inpatient Services (overnight hospital/facility stays)	<p>NETWORK: 20% or 0% Coinsurance¹</p> <p>NON-NETWORK: 40% or 30% Coinsurance¹</p>
Outpatient Services (without overnight hospital/facility stays)	<p>NETWORK: 20% or 0% Coinsurance¹</p> <p>NON-NETWORK: 40% or 30% Coinsurance¹</p>
Emergency Room Services	<p>NETWORK: 20% or 0% Coinsurance¹</p> <p>NON-NETWORK: 20% or 0% Coinsurance¹</p>
Preventive Care Services	<p>Covers all nationally recommended preventive care services, including well-child care, immunizations, PSA screenings, Pap tests, mammograms, colorectal cancer screenings and more. Child immunizations are covered at 100% in network from birth through age 5.</p> <p>NETWORK: Preventive Office Visit \$30 Copayment, deductible waived, for primary care physician; \$40 Copayment, deductible waived, for specialist; No Office Copayment Option (available on \$1,500/20% and \$2,500/0%) Office visits 20% Coinsurance (deductible waived); Other Preventive Services (for all plan deductibles) 20% Coinsurance (deductible waived)</p> <p>NON-NETWORK: 40% or 30% Coinsurance¹</p>
Maternity	Not Covered (see Optional Coverage below)
Optional Coverage (at additional cost)	Dental, Life, Maternity (optional maternity rider available for purchase with \$2,500 Individual/\$5,000 Family or greater deductible; subject to 12-month waiting period)

Prescription Drug Coverage Premier

Retail Drugs (and Mail Order Drugs when available)	<p>Standard Drug Coverage:</p> <p>Separate \$250 per person deductible for Tiers 2, 3 and 4. Member is responsible for the difference in allowable charge between Brand and Generic, plus copayment or coinsurance.</p> <p>NETWORK:</p> <ul style="list-style-type: none"> Tier 1 Drugs: Retail (30 day supply): \$15 Copayment; Mail Order (90 day supply): \$30 Copayment Tiers 2, 3, and 4: Greater of \$30 Copayment or 40% Coinsurance for both Retail (30 day supply) or Mail Order (90 day supply). Up to \$4,000 annual Prescription Drug out-of-pocket maximum per member. <p>NON-NETWORK:</p> <ul style="list-style-type: none"> 50% Coinsurance (minimum \$60) per prescription. Mail order not covered.
--	---

Optional Drug Coverage (when available)	<p>Upgrade Drug Coverage:</p> <p>NETWORK:</p> <ul style="list-style-type: none"> Retail Drugs (30 day supply): Tier 1 (\$15 Copayment)/Tier 2 (\$30 Copayment)/Tier 3 (\$60 Copayment)/Tier 4 (25% Coinsurance); separate \$2,500 annual Prescription Drug out-of-pocket maximum) Mail Order Drugs (90 day supply): Tier 1 (\$30 Copayment)/Tier 2 (\$75 Copayment)/Tier 3 (\$150 Copayment)/Tier 4 (25% Coinsurance); separate \$2,500 annual Prescription Drug out-of-pocket maximum) <p>NON-NETWORK:</p> <ul style="list-style-type: none"> Retail Drugs (30 day supply only): 50% Coinsurance (minimum \$60) per prescription
---	--

Other Covered Benefits include but are not limited to: Ambulance, Chiropractic, Durable Medical Equipment, Home Health Care, Hospice Care, Organ Transplants, Rehabilitation Facilities, Skilled Nursing Care, Therapy Services, Vision Exam, Urgent Care

¹ Coinsurance is designated by the plan you choose.
NOTE: Network and non-network deductibles are separate and do not accumulate toward each other. Network and non-network out-of-pocket maximums are also separate and do not accumulate toward each other.

IMPORTANT: This Benefit Guide is intended to be a brief outline of coverage and is not intended to be a legal contract. The entire provisions of benefits, limitations and exclusions are contained in the Contract/Certificate of Coverage. In the event of a conflict between the Contract/Certificate of Coverage and this Benefit Guide, the terms of the Contract/Certificate of Coverage will prevail.

Give yourself every advantage...

Good health and a bright smile.

Dental Blue® Plans

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

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

How dental networks help you save

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

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

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

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

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

*Per member, per calendar year

All plans include discounts on non-covered services like teeth whitening and orthodontia. This is only a summary of Dental Blue benefits. For complete benefit details, please refer to your Individual Dental Contract.

Optional Term Life Insurance

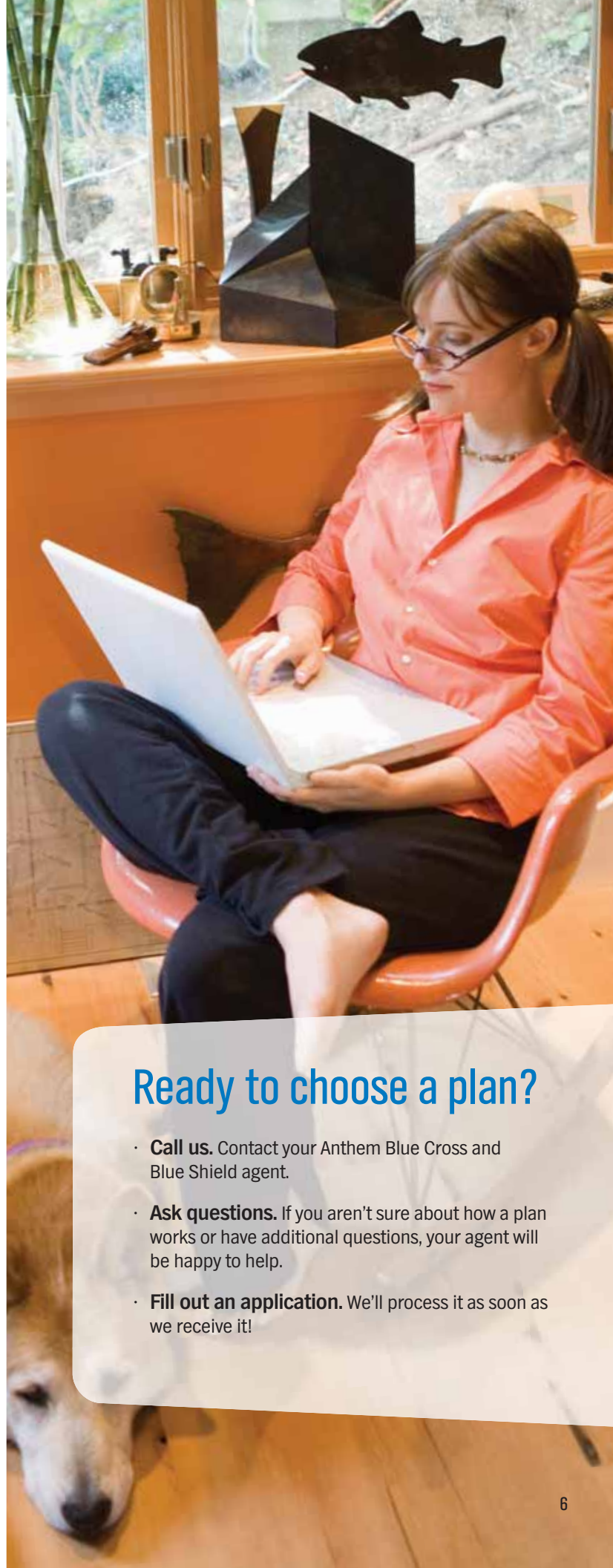
You can add Anthem Blue Preferred® Term Life Insurance to your health coverage. It's easy. There are no medical exams or extra forms to fill out. Simply use your application to apply for coverage.

Term Life Monthly Rates			
Age	\$15,000	\$25,000	\$50,000
1-18	\$1.50	\$2.50	N/A
19-29	\$2.85	\$4.75	\$9.50
30-39	\$3.30	\$5.50	\$11.00
40-49	\$7.50	\$12.50	\$25.00
50-59	\$20.85	\$34.75	\$69.50
60-64	\$29.40	\$49.00	\$98.00

Additional information

Save time with automatic premium payments

Hate writing checks? After your initial payment, our Electronic Fund Transfer (EFT) program will automatically withdraw funds from your bank account each month to pay for your health plan premium. You'll not only save on postage, you won't have to worry about a lapse in coverage because you forgot to mail in your payment. To sign up, just fill out the billing section of the enrollment application.



Ready to choose a plan?

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



Health. Join In.

Individual and Family Health Care Plans
for **Wisconsin**

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 exclusions, limitations, and terms of this coverage, please see the enclosed Coverage Details. This document should be included with your information kit, or if you have printed this brochure from your computer, it should be at the end. If you did not 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 Contract/Certificate of Coverage, the provisions of the Contract/Certificate of Coverage will prevail. Benefits and premiums are subject to change.

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!

Anthem Blue Cross and Blue Shield is the trade name of 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. Life and Disability products are underwritten by Anthem Life Insurance Company. 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.

Wisconsin Coverage Details

Things you need to know before you buy...

SmartSense[®], Premier, CoreShareSM, Lumenos[®] HSA and Blue Access[®] Value

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

Who Can Apply?

You can apply for coverage for yourself or with your family. You must be a resident of Wisconsin, under the age of 65, not eligible for Medicare and a legal resident of the U.S. You must also not be covered by any other group or individual health plan and meet our underwriting guidelines. Family health coverage includes you, your spouse or domestic partner and any unmarried dependent children under the age of 27. (Except for certain dependent children who are over age 27 and return to full-time student status at the end of an active military service period. See the Contract for further details.)

What's A Pre-Existing Condition?

Generally, our plans cover pre-existing conditions after you've been enrolled in the plan for 12 months. A pre-existing condition is any undisclosed condition that was diagnosed, treated or for which a health care provider recommended that you receive care or treatment within the 12 months right before you enrolled.

If you apply for coverage within 63 days of terminating your membership with another "creditable" health care plan, then you can use your prior coverage for credit toward the 12-month waiting period. Anthem Blue Cross and Blue Shield will credit the time you were enrolled on the previous plan.

Access to the Medical Information Bureau (MIB)

Information regarding your insurability will be treated as confidential. Anthem Blue Cross and Blue Shield or its reinsurers may, however, make a brief report thereon to the MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act.

The address of MIB's Information Office is:
50 Braintree Hill Park, Suite 400
Braintree, MA 02184-8734

Information for consumers about MIB may be obtained on its website at www.mib.com. Anthem Blue Cross and Blue Shield, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

What Our Individual Health Care Plans Do Not Cover

The following Exclusions and Limitations will help you understand what your health care plan does not include before you enroll. These are just some of the plans' limitations and exclusions. Check your Contract or Certificate of Coverage for a complete listing of benefits, exclusions and maximum payment levels.

Medical Exclusions And Limitations

Our plans do not provide benefits for:

- Services, supplies or charges having to do with pre-existing conditions (see "What's A Pre-Existing Condition?")
- Charges incurred prior to the effective date of coverage or after the termination date of coverage
- Private duty nursing
- Maternity services, unless an optional maternity rider is purchased on the Premier or Lumenos HSA plans
- Treatment of mental health and substance abuse unless mandated
- Experimental or investigative treatment
- Dental, except as spelled out in your Contract
- Charges greater than the maximum allowable amount (charges exceeding the amount Anthem recognizes for services)
- Benefits covered by Medicare or a governmental program
- Care provided by a member of your family
- Educational services
- Comfort and/or convenience items
- Treatment that's primarily intended to improve your appearance
- Weight loss programs or treatment of obesity
- Hearing aids, except as stated in your Contract for children under age 18
- Eyeglasses or contact lenses
- Radial keratotomy or keratomileusis or excimer laser photo
- Vision services, except as stated in your Contract
- Sclerotherapy
- Routine foot care

Medical Exclusions And Limitations (continued)

- Artificial insemination, fertilization, infertility drugs or sterilization reversal
- Sex transformation surgery
- Custodial care
- Artificial and mechanical hearts
- Specialty drugs purchased at non-network pharmacies
- Over-the-counter drugs, devices or products
- Workers' compensation
- Services we determine aren't medically necessary

Our plans also limit the following outpatient services

- Physical therapy, speech therapy and occupational therapy are limited to 20 visits each, combined network and non-network
- Home health care services limited to 60 visits except for Blue Access Value which is limited to 40 visits
- Optional maternity rider subject to a 12-month waiting period
- Pre-existing conditions subject to a 12-month waiting period

Our Appeal Rights And Confidentiality Policy

If we deny a claim or request for benefits completely or partially, we will notify you in writing. The notice will explain why we denied the claim/request. You may contact Customer Service if you have questions concerning the denial. You may also file a grievance by sending a letter to us. You should send any additional information that supports your grievance and state all the reasons why you feel the grievance request should be granted. We will review your grievance and let you know our decision in writing, usually within 30-60 days of receiving your grievance. You may also have the right to request an external review. For more information on the grievance and external review of other rights, please review your Contract or Certificate of Coverage.

In addition to your rights to file a complaint or grievance concerning your claim or benefit denial, you may also be entitled to an independent review by medical professionals who have no connection to this insurer to address the concerns you have about your claim. Typically, you must first complete the insurer's internal grievance process before you can initiate an independent review. However, you do not need to complete the grievance process if you need immediate medical treatment and the time period for completing the grievance process will cause a delay that could jeopardize your life or health or we agree with you that it is in everyone's best interest to proceed with your concern directly to independent review. Unless our notice of decision includes a different address, send requests for a review of appeal to:

Anthem Blue Cross and Blue Shield
Attn: Wisconsin Grievance Unit
P.O. Box 33200
Louisville, Kentucky 40232-3200

You may also contact the Office of the Commissioner of Insurance (OCI), if you have a complaint at: OCI Complaints Department, P.O. Box 7873, Madison, WI 53707-7873 or call at: 1-800-236-8517 / if in Madison at 266-0103. In addition to the appeals processes we just described, Anthem has adopted a confidentiality policy in Wisconsin. This policy includes guidelines regarding the protection of confidential member information and a member's right to access and change information in Anthem's possession. The policy clearly points out when a member needs to sign a release before Anthem can disclose information to a member's provider, spouse or other family members.

We Want You To Be Satisfied

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

This document is not a part of the Contract or Certificate of Coverage. If you are approved for coverage, the Contract or Certificate of Coverage you receive will include all the details of your plan. In the event of a conflict between the information in this brochure and your Contract or Certificate of Coverage, the terms of your Contract or Certificate of Coverage will prevail. Read your Contract or Certificate of Coverage carefully. Anthem has the right to rescind, cancel, terminate or reform your coverage based on provisions described in the Contract or Certificate of Coverage.

Selecting health coverage is an important decision.

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