Insurance ISMA Agency

322 Canal Walk • Indianapolis, IN 46202-3268

(317) 261-2060 • Toll free: (800) 257-4762 • www.ismanet.org

The ISMA Insurance Agency is pleased to provide this packet of information on the Indiana State Medical Association sponsored Anthem health insurance plan for ISMA members and their families.

This packet includes:

- Medical, Life and Dental Insurance brochure
- Anthem Enrollment Application

To request firm rates for each plan, please complete the Anthem Enrollment Application, then scan and email the application to Donna Mallinckrodt at dmallinckrodt@ismanet.org, or fax it to Donna at (317) 261-2238, which is a private fax number.

Upon receipt, we will forward the application to Anthem Underwriting for review and rating. And we will then email firm rates for each plan option for your consideration.

If you have any questions, please email Donna Mallinckrodt at dmallinckrodt@ismanet.org or call Donna at (317) 454-7743.

Medical and Dental Insurance

for members of the ISMA and their families

July, 2018 - June, 2019

(317) 261-2060 • (800) 257-4762 • www.ISMAIA.com

Check out our **PPO Plans**
and our **Health Savings Account Plans**

ISMA
INDIANA
STATE
MEDICAL
ASSOCIATION

Insurance ISMA Agency

Health Insurance - PPO and HSA Plans Available

UNIQUE ADVANTAGES

- ✓ This health policy can provide physicians with seamless coverage from practice to retirement – and beyond.
- ✓ Surviving spouses and children of deceased ISMA members may continue coverage, provided the member was covered immediately prior to death. Spouses are eligible for the rest of their lives or until remarriage; children are eligible through the end of the year in which they attain age 26.
- ✓ Once subscribers attain age 65, they are eligible for a Medicare Carve-out plan when Medicare is primary. (Subscribers are automatically changed to the Medicare Carve-out, and separate policies are automatically created for any covered dependents.)
- ✓ Children can be covered under parents' policies through the end of the year in which they attain age 26, regardless of tax, student or marital status.
- ✓ Children are eligible for separate policies from the date they are removed from parents' policies through the end of the year in which they attain age 29, at the low Member Only rate, provided the parent is insured in the ISMA program.
- ✓ Knowledgeable ISMA employees and agents provide customer service for all aspects of the plan aside from claims processing, which is handled by Anthem.
- ✓ Premiums are discounted based on favorable claims experience.
- ✓ All ISMA plans use the broad Anthem Blue Access Network, providing network benefits for a very wide selection of physicians, other medical professionals, hospitals and medical facilities. Many competitive plans use more restrictive networks that limit the selection of network providers.
- ✓ More consistent annual renewal rate adjustments than many competitive plans.
- ✓ All plans have two deductibles per family instead of three, which is common among competitive plans.

Information You Should Know

- Deductibles and coinsurance start over on January 1 of each year.
- Individual health insurance policy premiums are reviewed on July 1 of each year.
- You may request changes from one medical plan to another on your plan's annual renewal date. (Requests to upgrade plans may be subject to underwriting approval and may not be guaranteed.) Additionally, you may request an off cycle change to a plan with a lower premium one time per year, 4 or more months before your plan's annual renewal date.
- Newborn children must be added by contacting ISMA within 31 days of birth to be covered under the plan.

What is a Health Savings Account (HSA)?

Anthem HSA plan options are compatible with a Health Savings Account (HSA), which combines high deductible health insurance with a tax-favored savings account. Money in the savings account can be used to pay for eligible medical expenses as well as deductibles, coinsurance, prescriptions, vision expenses and dental care. Unused funds roll over year to year. HSAs offer the potential to build more savings through investing. After age 65, HSA funds can be withdrawn for any purpose without penalty, but may be subject to income tax if not used for IRS-qualified medical expenses.

A Valuable Benefit For…

- Physicians who are members of the Indiana State Medical Association, their spouses (or domestic partners subject to certain requirements), and their children through the end of the year in which they attain age 26.

Save Money with Discounts

- While the Anthem medical plans do not provide benefits for routine vision exams, eyeglasses or contacts, as an Anthem customer, you will qualify for discounts on eyeglasses and contacts through providers like LensCrafters®, Pearle Vision®, Target Optical®, Sears Optical℠ and 1-800-Contacts®.
- Discounts are also offered on gym memberships, fitness equipment, coaching, weight-loss programs, smoking cessation programs, hearing aids, vitamins, minerals, supplements, pet insurance and more.
- It's just one more reason to choose Anthem Blue Cross and Blue Shield. Log into your Member account at **www.anthem.com** and click on **Discounts** to learn more.

Dental Insurance Plan (optional)

An optional Dental Plan is offered, providing benefits for these services:

- Diagnostic and Preventive
- General (Adjunctive), Restorative, Endodontic, Oral Surgery, Periodontal
- Prosthodontic
- Orthodontic (through age 19)

See Dental page of this brochure for more information.
(Medical coverage is required.)

ISMA sponsors the following Anthem medical insurance plans

All plans use the Anthem Blue Access Network; search for providers at ***www.anthem.com***

Under the following plans, each covered person must meet the individual deductible. However, when a policy covers three or more people, no further deductible is applied after the family maximum deductible is met.

Choose a PPO plan with copay benefits for office vists, urgent care, ER, and prescription drugs

	Preventive Care[2]		Office Visit[5] PCP=Primary Care Physician SCP = Specialty Care Physician AI = Allergy Injection		Urgent Care		Emergency Room		Prescription Drugs Tier 1 /Tier 2 /Tier 3 /Tier 4 (Specialty)		Deductibles[4]		Coinsurance[4] (After deductible, plan pays part of costs, you pay part of costs)		Out of Pocket Maximum[4]	
Plan Name	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	Retail (30-day supply) Copays	Mail Order (90-day supply) Copays	In Network Single /Family	Out of Network Single /Family	In Network Plan pays /You pay	Out of Network Plan pays /You pay	In Network Single /Family	Out of Network Single /Family
PPO 1,000 /2,000	100%	DC[1]	$25 PCP copay $50 SCP copay $5 AI copay	DC[1]	$75 copay	DC[1]	$250 copay plus 20%	DC[1]	$10/$30/$60 /25% up to $300 max.[3]	$20/$60/$120 /25% up to $300 max.[3]	$1,000 $2,000	$5,000 $10,000	80% 20%	50% 50%	$3,500 $7,000	$10,000 $20,000
PPO 2,000 /4,000	100%	DC[1]	$25 PCP copay $50 SCP copay $5 AI copay	DC[1]	$75 copay	DC[1]	$250 copay plus 20%	DC[1]	$10/$30/$60 /25% up to $300 max.[3]	$20/$60/$120 /25% up to $300 max.[3]	$2,000 $4,000	$5,000 $10,000	80% 20%	50% 50%	$5,000 $10,000	$10,000 $20,000
PPO 3,000 /6,000	100%	DC[1]	$25 PCP copay $50 SCP copay $5 AI copay	DC[1]	$75 copay	DC[1]	$250 copay plus 20%	DC[1]	$10/$30/$60 /25% up to $300 max.[3]	$20/$60/$120 /25% up to $300 max.[3]	$3,000 $6,000	$5,000 $10,000	80% 20%	50% 50%	$6,500 $13,000	$10,000 $20,000
PPO 5,000 /10,000	100%	DC[1]	$25 PCP copay $50 SCP copay $5 AI copay	DC[1]	$75 copay	DC[1]	$250 copay plus 20%	DC[1]	$10/$30/$60 /25% up to $300 max.[3]	$20/$60/$120 /25% up to $300 max.[3]	$5,000 $10,000	$10,000 $20,000	80% 20%	50% 50%	$7,350 $14,700	$20,000 $40,000

Choose a plan you can pair with a Health Savings Account through an HSA provider of your choice to take advantage of HSA tax benefits

HSA 2,700 /5,400	100%	DC[1]	DC[1]	DC[1]	DC[1]	DC[1]	DC[1]	DC[1]	Discount, DC[1]	Discount, DC[1]	$2,700 $5,400	$5,000 $10,000	100% 0%	50% 50%	$2,700 $5,400	$10,000 $20,000
HSA 3,000 /6,000	100%	DC[1]	DC[1]	DC[1]	DC[1]	DC[1]	DC[1]	DC[1]	Discount, DC[1]	Discount, DC[1]	$3,000 $6,000	$5,000 $10,000	80% 20%	50% 50%	$4,000 $8,000	$10,000 $20,000
HSA 4,000 /8,000	100%	DC[1]	DC[1]	DC[1]	DC[1]	DC[1]	DC[1]	DC[1]	Discount, DC[1]	Discount, DC[1]	$4,000 $8,000	$10,000 $20,000	80% 20%	50% 50%	$5,000 $10,000	$20,000 $40,000
HSA 5,000 /10,000	100%	DC[1]	DC[1]	DC[1]	DC[1]	DC[1]	DC[1]	DC[1]	Discount, DC[1]	Discount, DC[1]	$5,000 $10,000	$10,000 $20,000	80% 20%	50% 50%	$6,650 $13,300	$20,000 $40,000

1 DC = Anthem's allowable amounts are covered, subject to Deductible and Coinsurance (if applicable).
2 See Preventive Care item under **What's Covered** for more detailed description of benefits for each plan.
3 Copays for Tier 1/2/3/4 prescription drugs. The copay listed for tier 4 (Specialty) drugs is 25%, up to a maximum of $300 per prescription.
4 All plans have separate In Network and Out of Network Deductibles, Coinsurance and Out of Pocket maximums.
5 Allergy testing, MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds, and pharmaceutical products subject to deductible and coinsurance.

All plans feature an unlimited lifetime maximum benefit

Definitions

- **Deductibles:** Charges for certain services are subject to deductibles that accumulate from January 1 through December 31 of each year. All plans have separate In Network (IN) and Out of Network (OON) deductibles.
- **Copays:** Copays are specific amounts that you are required to pay at the time of certain services, i.e., office visits, urgent care center visits, emergency room visits.
- **Coinsurances:** After deductibles are met, the plan pays part of the costs and the subscriber pays part of the costs, until the Out of Pocket Maximum is reached.
- **Out of Pocket Maximum: The Out of Pocket Maximum is satisfied by all deductibles, copays and coinsurances** (except human organ and tissue transplants, excluding kidney and cornea).

What's Covered

- **Preventive Care:** PPO plans: Cover physical exams, well baby care, immunizations, diagnostic services performed during the office visit session and billed by the physician, including routine Pap smears and routine mammograms – In network covered at 100%; Out of network subject to OON deductible and coinsurance. HSA plans: Cover all In-network care coded as preventive at 100%.
- **Physician Home and Office Services:** PPO plans: Primary Care Physician and Specialty Care Physician home and office visits covered, subject to Office Visit copays listed in Plan Options chart. $5 copay for allergy injections. Allergy testing, MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds, and pharmaceutical products are subject to deductible and coinsurance. HSA plans: Subject to deductible and coinsurance.
- **NEW! LiveHealth Online®:** With LiveHealth Online, you get immediate doctor visits through live video, your choice of U.S. board-certified doctors, private, secure and convenient online visits. For more information or to sign up, go to **www.LiveHealthOnline.com**. PPO plans: Subject to PCP copay. HSA plans: A cost of only $49 per visit, subject to deductible and coinsurance.
- **Urgent Care:** (Includes all services billed with urgent care encounter claim.) PPO plans: In network $75 copay. Out of network subject to OON deductible and coinsurance. HSA plans: Subject to deductible and coinsurance.
- **Emergency Room:** (Includes all services performed, facility and professional; waived if admitted.) PPO plans: In network $250 copay followed by 20% coinsurance. Out of network subject to OON deductible and coinsurance. HSA plans: Subject to deductible and coinsurance.
- **Prescription Drugs:** Oral contraceptives covered under all plans. PPO plans: Rx copay benefits for Tier 1, 2, 3 and 4 drugs. See Plan Options chart for copay amounts. HSA plans: Prescription Drug discount, charges subject to deductible and coinsurance; then covered in full.
- **Inpatient Hospital Care:** Unlimited number of days of semi-private room or ward accommodations and other necessary services not included in the room charges.
- **Inpatient and Outpatient Professional Services:** All plans: Include, but are not limited to Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams.
- **Diagnostic X-rays and Lab Tests:** Subject to deductible and coinsurance.

What's Not Covered

LIMITATIONS

Unless otherwise noted, covered charges are based on Anthem's allowable amounts.

EXCLUSIONS FOR MEDICAL PLANS

(complete list of exclusions printed in Certificate)
Services not covered under the Medical Plans include services or supplies not medically necessary, vision exams, cosmetic surgery, dental care not caused by an accident unless you are covered under the Dental Plan, eyeglasses or hearing aids, services covered by worker's compensation.

Compliance

- All medical plans are Affordable Care Act compliant.
- The ISMA issues 1095-B forms to all subscribers to document for tax purposes your purchase of qualifying health coverage.

Wellness

Wellness education and resources are offered by Anthem at **timewellspent.anthem.com**, offering tools for prevention, living well and eating healthy.

Creating an Anthem Member Account

Anthem makes it easy for subscribers to create an online user account to view benefits, check year-to-date deductibles, review claims, order new ID cards, refill mail order prescriptions - and more. To begin using Anthem online access, go to **www.Anthem.com**, click **Log in or start your member registration**, and follow the prompts to set up a Member account. You will need some information from your Anthem ID card.

- **Surgery:** Subject to deductible and coinsurance.
- **Anesthesia:** Subject to deductible and coinsurance.
- **Mental Health/Substance Abuse:** PPO plans: In network physician office visits, subject to primary care office visit copay. Outpatient professional and facility services subject to deductible and coinsurance. Out of network subject to OON deductible and coinsurance. In network inpatient professional and facility services subject to deductible and coinsurance; Out of network subject to OON deductible and coinsurance. HSA plans: Subject to deductible and coinsurance.
- **Maternity:** Subject to deductible and coinsurance.
- **Infertility:** All plans include $5,000 lifetime maximum benefit per person for treatment of infertility.
- **Ambulance:** Subject to deductible and coinsurance.
- **Medical Supplies, Equipment and Appliances:** Subject to deductible and coinsurance.
- **Outpatient Therapy:** All plans include 60 physical/occupational therapy visits, 20 speech therapy visits, 12 spinal manipulation visits, 36 cardiac rehabilitation visits and 20 pulmonary rehabilitation visits per calendar year. PPO plans: In network copay based on setting; Out of network subject to OON deductible and coinsurance. HSA plans: Subject to deductible and coinsurance.
- **Skilled Nursing Facility:** 90 days per calendar year combined Network and Non Network.
- **Approved Home Health Care Services:** All plans include 100 visits per calendar year.
- **Private Duty Nursing:** 82 visits per calendar year combined Network and Non Network; 164 visits per lifetime combined Network and Non Network.
- **Foreign Travel:** Same benefits paid in or outside the U.S. Outside the U.S., subscriber may be required to pay provider at time of service, and file a claim form and an itemized bill with Anthem upon return. Please note: If you travel outside the Untied States and want coverage for international air ambulance, you may want to purchase a separate air medical evacuation insurance policy.
- **Hospice Services:** PPO plans: Covered in full. HSA plans: Subject to deductible and coinsurance.
- **Human Organ or Tissue Transplant:** Covers these human to human organ and tissue transplants: bone marrow, heart, heart/lung, lung, liver, pancreas and kidney/pancreas. In network covered at 100%; out of network 50% coinsurance. Kidney and cornea transplants covered under health benefit.
- **Mandatory Precertification on Inpatient and Selected Outpatient Services with Noncompliance Penalty:** Contact Anthem Customer Service Department to determine whether precertification is required on a particular Outpatient Service. In network penalties are provider's responsibility. Out of network, subscriber is responsible for non-medically necessary services.
- **Benefit Management Program:** In catastrophic/chronic cases, alternative means of care may be offered, subject to approval of the insured and the attending physician, i.e., skilled nursing facility, home health care, hospice care or special medical equipment such as ventilators and respirators.
- **BlueCard Program:** In many cases, when you travel or live outside your Blue Cross and Blue Shield Plan's service area, you can take advantage of savings the local Blue Plan has negotiated with local doctors and hospitals. You should not have to pay any amount above negotiated rates. Also, you should not have to complete a claim form or pay up front for your health care services, except for out-of-pocket expenses like non-covered services, deductible, copay, and coinsurance that you'd pay anyway. More than 85 percent of all doctors and hospitals throughout the U.S. contract with Blue Cross and Blue Shield Plans. Outside of the U.S., you have access to doctors and hospitals in more than 200 countries. If you're a PPO member, always use a BlueCard PPO doctor or hospital to make sure you receive the highest level of benefits. **Visit the BlueCard Doctor and Hospital Finder Web site (www.BCBS.com) or call 1-800-810-BLUE to locate doctors and hospitals outside of your Blue Plan's service area.**

Multiple Payment Options

You can choose to be billed by mail on a monthly, quarterly, semi-annual or annual basis.

Or, you can make automatic monthly payments with our Direct Payment Via ACH (ACH Debit) Plan. You'll save on postage and check-writing costs, plus your payments will always be on time — even when you're away from home.

To join the Direct Payment Via ACH (ACH Debit) Plan, 1) find and print the Payment Authorization Form at **www.ismaia.com**, **RESOURCES**, 2) read the terms and conditions, 3) complete and print the form, 3) sign, and 4) fax the completed form and a voided check to ISMA Insurance Agency's private fax line, (317) 261-2238.

How to Apply

Review this brochure. Then, follow these easy steps: 1) Complete and sign an Anthem Enrollment Application for Individuals. (Form available at **www.ismaia.com** under **Individual Plans**).

Scan and email the Enrollment Application to **ismaia@ismanet.org**, or fax it to ISMA Insurance Agency's private insurance fax line, (317) 261-2238.

Upon receipt of your completed application, an appropriate risk class will be assigned based on medical history, and you will be provided with firm rates for each medical plan option. If you accept, the ISMA will send a New Policy Confirmation and an initial invoice, and Anthem will send an identification card (within 10-14 business days of entry into Anthem's system).

For More Information

For more information, please call the ISMA Insurance Agency at (800) 257-4762, email us at **ismaia@ismanet.org**, or go to **www.ISMAIA.com**.

This is not meant as a replacement to the Certificate of Coverage (Certificate) and whenever a discrepancy exists between the Certificate and this brochure, the Certificate will govern the administration of the plan.

The ISMA Dental Plan

Dental Plan Highlights

OPTIONAL DENTAL PLAN

You may include dental coverage for the additional monthly rate shown in the first row of the rate chart. The Dental Plan is available only in addition to the medical coverage. Dental coverage can be elected upon enrollment or added at any annual renewal date.

DEDUCTIBLE

$50 per person per calendar year, **or $150 per family** per calendar year (whichever occurs first). Applies to all benefits except diagnostic, preventive, and orthodontia.

MAXIMUM BENEFIT

Maximum **$1,500 per person benefit** per calendar year. Maximum **$1,000 per person orthodontia benefit** per lifetime, which does not count toward the annual maximum benefit.

INDIANA ANTHEM DENTAL NETWORK

If you purchase the Dental Plan and your dentist is in the Indiana Anthem Dental network, you will not be responsible for amounts billed over Anthem's allowable amounts. And your preventive and diagnostic services will be paid at 100 percent.

To determine if your dentist is in the Indiana Anthem Dental network, visit anthem.com and search for Indiana Anthem Dental network providers.

Category	Deductible Applies	Your Responsibility		Covered Services
		Network	Non-Network	
Diagnostic and Preventive		CIF*	20%	Oral evaluations, X-rays, cleanings, space maintainers and other selected diagnostic and preventive services.
General (Adjunctive), Restorative, Endodontic, Oral Surgery, Periodontal	X	20%	20%	Emergency palliative treatment, consultations, general anesthesia and I.V. sedation for surgical procedures, office visits for observation, and other selected general services. Amalgam and composite restorations and pin retention procedures. Root canal therapy, apexification, therapeutic pulpotomy and other selected endodontic services. Simple and surgical tooth extractions and other selected oral surgery services. Gingivectomy, crown lengthening, osseous surgery, soft tissue grafts and other selected periodontal services.
Prosthodontic (1 yr waiting period)	X	50%	50%	Crowns/onlays, partial and full dentures and other selected prosthodontic services.
Orthodontic (1 yr waiting period; $1,000 per person lifetime benefit)		50%	50%	Non-surgical dental services related to the supervision, guidance and correction of growing or mature teeth; covered services include examination, records, tooth guidance and repositioning (straightening) of the teeth. Orthodontia benefits cease at end of Benefit Period in which Member reaches age 19.

* CIF = Covered in full

Exclusions for the Dental Plan: Charges for implants; facings on crowns or pontics posterior to the second bicuspid; lost or stolen appliances, dentures or fixed bridgework. Certificate contains complete list of charges not covered.

ISMA INDIANA STATE MEDICAL ASSOCIATION

Insurance ISMA Agency

Check us out online at www.ISMAIA.com

Anthem Blue Cross and Blue Shield provides the ISMA-sponsored medical and dental plans. This brochure is provided to help you decide which plan to choose. It is not a contract, and it is not a complete description of the benefits, exclusions and limitations of any plan.

Effective 7/1/2018.

Enrollment Application

Individual

Anthem

Indiana State Medical Association

Please complete in ink and return to your employer. Use extra sheets of paper if necessary. *All information given should apply to this employer.*
To search Blue Access℠ PPO Providers, visit www.anthem.com

1. Billing Address					
Group #		**Request. Effective Date**			**Applicant # / Dept. name**
		/ /			
Anthem use: Plan	**Health Effective Date**		**Dental Effective Date**	**COB**	**Pre-ex (date)**
	/ /		/ /	☐ Yes ☐ No	/ /
ISMA use: Agent	**Risk Class**	**Bill Cycle**		**Record #**	
		M Q S Y		**ME #**	

2. Reason for Application
☐ New enrollment ☐ New hire
☐ Waiver ☐ Rehire (date) ___/___/___
☐ Annual open enrollment ☐ Add dependent (see section 3)

Qualifying event _____ Event date ___/___/___

3. Status Change/Event
Event date ___/___/___ ☐ Adoption*
☐ Marriage ☐ Legal Guardianship*
☐ Birth ☐ Other _____
**Include legal documentation.*

4. Type of Coverage/Plan

Health Coverage
☐ Employee only
☐ Employee + spouse
☐ Employee + child(ren)
☐ Family coverage
☐ No coverage
Medical Plan Name _____

Dental Coverage
☐ Yes
☐ No

5. Employee Information

Last name	First name, M.I.	Date of birth / /	Age	Sex ☐ M ☐ F	Social security # – –	☐ Single ☐ Divorced ☐ Married	Height	Weight

Home address	City	State	ZIP code	County (KY residents include Municipality)

Home telephone ( ) –	Business telephone ( ) –	eMail Address

Are you: Retired? ☐ Yes ☐ No	Disabled? ☐ Yes ☐ No	Hospitalized? ☐ Yes ☐ No	Occupation	Full time hire date / /	Hours working per week	Income reported by: ☐ W2 ☐ 1099 ☐ Other: _____

6. Family Information ***Spouse and dependents to be covered. (Attach a separate sheet if necessary.)***

1 Last name	First name, M.I.	Relationship to applicant ☐ Spouse ☐ Son ☐ Daughter ☐ Other _____	Fulltime student? ☐ Yes ☐ No

Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)

Date of birth / /	Sex ☐ M ☐ F	Social Security # – –	Height	Weight	Eligible for federal income tax exemption? ☐ Yes ☐ No Court ordered health care coverage? ☐ Yes ☐ No (If yes, include legal documentation) Currently hospitalized or disabled? ☐ Yes ☐ No (If yes, give reason)

2 Last name	First name, M.I.	Relationship to applicant ☐ Spouse ☐ Son ☐ Daughter ☐ Other _____	Fulltime student? ☐ Yes ☐ No

Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)

Date of birth / /	Sex ☐ M ☐ F	Social Security # – –	Height	Weight	Eligible for federal income tax exemption? ☐ Yes ☐ No Court ordered health care coverage? ☐ Yes ☐ No (If yes, include legal documentation) Currently hospitalized or disabled? ☐ Yes ☐ No (If yes, give reason)

3 Last name	First name, M.I.	Relationship to applicant ☐ Spouse ☐ Son ☐ Daughter ☐ Other _____	Fulltime student? ☐ Yes ☐ No

Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)

Date of birth / /	Sex ☐ M ☐ F	Social Security # – –	Height	Weight	Eligible for federal income tax exemption? ☐ Yes ☐ No Court ordered health care coverage? ☐ Yes ☐ No (If yes, include legal documentation) Currently hospitalized or disabled? ☐ Yes ☐ No (If yes, give reason)

4 Last name	First name, M.I.	Relationship to applicant ☐ Spouse ☐ Son ☐ Daughter ☐ Other _____	Fulltime student? ☐ Yes ☐ No

Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)

Date of birth / /	Sex ☐ M ☐ F	Social Security # – –	Height	Weight	Eligible for federal income tax exemption? ☐ Yes ☐ No Court ordered health care coverage? ☐ Yes ☐ No (If yes, include legal documentation) Currently hospitalized or disabled? ☐ Yes ☐ No (If yes, give reason)

5 Last name	First name, M.I.	Relationship to applicant ☐ Spouse ☐ Son ☐ Daughter ☐ Other _____	Fulltime student? ☐ Yes ☐ No

Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)

Date of birth / /	Sex ☐ M ☐ F	Social Security # – –	Height	Weight	Eligible for federal income tax exemption? ☐ Yes ☐ No Court ordered health care coverage? ☐ Yes ☐ No (If yes, include legal documentation) Currently hospitalized or disabled? ☐ Yes ☐ No (If yes, give reason)

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7. Other Health Coverage ***Please check one:*** ☐ *YES (complete below.)* ☐ *NO*

On the day your coverage begins, list family members, including yourself, who will be covered by any other health coverage.

Provide name, phone number and address of the HMO or insurance company		Policy/certificate number		Effective date / /
Policy/certificate holder's name	Social Security number – –	Date of birth / /	Relationship to applicant	

If you and/or your dependents are enrolled in Medicare Part A or Medicaid, complete the following.

Enrollee's name(s)	Medicare/Medicaid ID #	Medicare Part A effective date / /	Medicare Part B effective date / /	ESRD onset date / /
		/ /	/ /	/ /

Reason for Medicare enrollment:
☐ Age ☐ Disability ☐ ESRD & Disability ☐ End Stage Renal Disease (ESRD)

8. Prior Health Coverage ***Please check one:*** ☐ *YES (complete below.)* ☐ *NO*

Have you been covered by Anthem within the past two (2) years? ☐ Yes ☐ No Policy/Certificate #:	Group name/ID #	Dates policy in effect: / / — / /
Have you and/or your dependents had prior coverage with another carrier(s) within the past two (2) years? ☐ Yes ☐ No	List prior carrier(s)	Dates policy in effect: / / — / /

Please check the type of prior coverage
☐ Employee ☐ Employee / Spouse ☐ Employee / Child(ren) ☐ Employee / Spouse / Child(ren)

Termination reason: ☐ Divorce/legal separation ☐ Death of spouse ☐ COBRA coverage exhausted ☐ Employment terminated ☐ Group plan terminated ☐ Employer/group contribution ceased ☐ Other:

9. Medical Information

Please note that no person will be denied health coverage on an individual basis due to the answers provided below, except for Medicare Carve-Out.

(If yes, circle condition)

1. Do you or your dependents regularly take medication? ☐ Yes ☐ No
2. Has a physician told you or any of your dependents that surgery or special tests or treatment may be necessary in the future? ☐ Yes ☐ No
3. Are you or any of your dependents currently pregnant? ☐ Yes ☐ No

   If yes, name _____ due date ___/___/___
4. In the last 5 years have you or any of your dependents been diagnosed or treated for any: heart/circulatory condition; cancer/tumor; disorder of the blood or immune system; stroke, aneurysm, diabetes **(list age of onset below);** mental/nervous disorder, depression, alcohol or drug abuse/dependency; kidney, liver or pancreas disorder; ulcerative colitis; Crohn's disease; lupus; lung disorder; COPD; emphysema; arthritis; back/disk disorder; multiple sclerosis; or muscular dystrophy? ☐ Yes ☐ No
5. In the past 5 years have you or any of your dependents been diagnosed with AIDS or HIV? ☐ Yes ☐ No
6. Have you or any of your dependents visited the emergency room on 2 or more occurrences for the same condition in the last 12 months? ☐ Yes ☐ No
7. Have you or your dependents used tobacco products in the last 12 months? ☐ Yes ☐ No

(If yes, circle condition)

8. To the best of your knowledge, have you or any of your dependents, within the last 5 years, had a diagnosis of or treatment for the following:
   a. Ulcer, hernia, diverticulitis, irritable bowel or other intestinal disorder? ☐ Yes ☐ No
   b. Thyroid, goiter or gallbladder disorder? ☐ Yes ☐ No
   c. High blood pressure, cholesterol or triglycerides? ☐ Yes ☐ No
   d. Anemia, chest pain, heart murmur or disorder of the veins/circulatory system? ☐ Yes ☐ No
   e. Rheumatic fever, carpal tunnel syndrome or disorder of the muscles or joints? ☐ Yes ☐ No
   f. Epilepsy, convulsions, paralysis or disorder of the brain or nervous system? ☐ Yes ☐ No
   g. Asthma, allergies, sinus, or disorder of the respiratory system? ☐ Yes ☐ No
   h. Any STD or disorder of the prostate, genital, reproductive or urinary system? ☐ Yes ☐ No
   i. Any disorder of the skin, ears, or eyes? ☐ Yes ☐ No
9. Have you or any of your dependents, within the last 2 years, engaged in skydiving, hang gliding, underwater diving, racing (any type), rodeo, mountaineering, professional sports, piloting a plane or are any such activities contemplated? ☐ Yes ☐ No
10. Are you or any of your dependents presently disabled or had a condition not identified above during the past 5 years? ☐ Yes ☐ No

Explain "YES" answers to any question. Give complete details to avoid delay. (Attach a separate sheet of paper if necessary)

Quest. #	Name of individual	Diagnosis	Treatment	Medication*	Date(s) of treatment	Hospitalized? (Y/N)	Surgery? (Y/N)	Recovered? (Y/N)	Physician's name
					/ /				
					/ /				
					/ /				
					/ /				
					/ /				
					/ /				

Please read the TERMS on the reverse side of this page. Your Signature is required on the reverse side of this to submit this application.

AIN-69I\ISMA (11/08) ****If you are using a generic medication, please be sure to list the generic name; brand name medications may result in higher premiums.***

Significant terms, Conditions and Authorizations (TERMS)

Please read this section carefully before signing the application.

1. I may not assign any payment under my Anthem Blue Cross and Blue Shield program.
2. I authorize deduction from my wages/pension, if necessary for the required premium for the coverage for which I, or any dependents have applied.
3. I am applying for the coverage selected on this application. If I select a coverage, or combination of coverages, not available to me and / or a class for which I am not eligible, I agree that my selection(s) is hereby automatically amended to be consistent with the employer's application.
4. I understand that, to the extent permitted by law, Anthem reserves the right to accept or decline this application (and that Anthem Life Insurance Company may accept only certain persons or conditions for coverage) and that no right whatsoever is created by this application. I also understand that this coverage, if approved, may exclude coverage for pre-existing conditions. (Ohio only - unless I applied for HMO/HIC coverage, in which case there is no such exclusion.)
5. I am responsible to timely notify my employer of any change that would make me or any dependent ineligible for coverage.
6. By signing this application, I agree and consent to the recording and / or monitoring of any telephone conversation between Anthem and myself.

I acknowledge that I have read the Significant Terms, Conditions and Authorizations, and I accept such provisions as a condition of coverage. I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and I understand they are being relied on by Anthem in accepting this application. I understand that any misstatements or failure to report new medical information prior to my effective date may result in a material change to coverage or premium rates. Any material misrepresentation or significant omission found in this application may result in denial of benefits or recission or cancellation of my coverage(s).

I give this authorization for and on behalf of any eligible dependents and myself if covered by the Plan. I am acting as their agent and representative.

Your health coverage will be provided by

In Indiana: Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc.

Thank you for choosing Anthem Blue Cross and Blue Shield

10. Read the TERMS section above carefully before signing. Please review your application for errors or omissions. By signing this, I am indicating that I have read and understand the language in the TERMS section of this application and agree to all of its terms.	
Applicant Signature	Date / /

11. PLEASE READ: If you are declining coverage for yourself, spouse, or dependents, you must complete and list all below, and sign and date application. Check all that apply. Waiving: ☐ Health ☐ Dental ☐ All		
Name of person waiving		Already protected by coverage of: ☐ Spouse ☐ Parent ☐ None ☐ Other
Employer name	Carrier: ☐ Anthem (giver certificate/policy #) ☐ Other carrier (give name, ID #)	
Check all that apply. Waiving: ☐ Health ☐ Dental ☐ All		
Name of person waiving	Already protected by coverage of: ☐ Spouse ☐ Parent ☐ None ☐ Other	Already protected by coverage of: ☐ Spouse ☐ Parent ☐ None ☐ Other
Employer name	Carrier: ☐ Anthem (giver certificate/policy #) ☐ Other carrier (give name, ID #)	
Check all that apply. Waiving: ☐ Health ☐ Dental ☐ All		
Name of person waiving		Already protected by coverage of: ☐ Spouse ☐ Parent ☐ None ☐ Other
Employer name	Carrier: ☐ Anthem (giver certificate/policy #) ☐ Other carrier (give name, ID #)	
Check all that apply. Waiving: ☐ Health ☐ Dental ☐ All		
Name of person waiving		Already protected by coverage of: ☐ Spouse ☐ Parent ☐ None ☐ Other
Employer name	Carrier: ☐ Anthem (giver certificate/policy #) ☐ Other carrier (give name, ID #)	

Check all that apply

☐ I certify that I have been given an opportunity to apply for Anthem Blue Cross and Blue Shield coverage and after careful consideration, have decided not to take advantage of this offer. In the event I wish to apply for such coverage hereafter, I may do so, subject to established procedures.

If I am declining enrollment for myself or my dependents (including my spouse) because of other health insurance coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that enrollment is requested within 31 days after other coverage ends. My dependent(s) or I may be subject to pre-existing condition restrictions or waiting periods specified in the group certificate, if a dependent or I are late enrollees. In addition, if I have a dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within 31 days after the marriage, birth, adoption or placement of adoption.

☐ I certify that I have been given the opportunity to apply for the available group life benefits offered by my employer/group, the benefits have been explained to me, and I and / or my dependent(s) decline to participate. Neither my dependent(s) nor I were induced or pressured by my employer/group, agent or life carrier, into declining this coverage, but elected of my (our) own accord to decline coverage. I understand that if I wish to apply for such coverage in the future, I may be required to provide evidence of insurability at my expense.

Applicant signature	Date / /