

PRE-MEDICARE

RETIREE BENEFIT PLANS

2009



MEDICARE



UNIVERSITY OF NOTRE DAME
Office of Human Resources

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PAGES WITH BLUE LETTERING ARE FOR THE PRE-MEDICARE PLAN

**PAGES WITH GREEN LETTERING ARE FOR THE MEDICARE PLAN
(AGE 65 AND OVER)**

RESOURCES

ADMINISTRATOR & PROVIDER DIRECTORY

Pre-Medicare Plans

Plan	Provider	Telephone Number	Internet Address
PPO Medical	Meritain PPO	1-888-668-6855	www.meritain.com
	Select Health Network (Local Network)	1-888-668-6855	www.selecthealthnetwork.com
	Beech Street (National Network)	1-800-432-1776	www.beechstreet.com
	New Avenues (Midwest Behavioral Health Network)	1-800-223-6246	www.newavenuesonline.com
HMO Medical Plans	Meritain Health HMOs	1-888-668-6855	www.meritain.com
CHA HMO	CHA Network	1-888-689-2242	www.chanetwork.com
Select HMO	Select Network	1-888-668-6855	www.selecthealthnetwork.com
Select HMO	New Avenues (Midwest Behavioral Health Network)	1-800-223-6246	www.newavenuesonline.com
Prescription Drug Plan	Medco	1-800-711-0917	www.medco.com

Medicare Plan

Plan	Provider	Telephone Number	Internet Address
Blue Traditional \$250	Anthem Blue Cross Blue Shield	1-800-280-7293	www.anthem.com
Blue Medicare RX	Anthem Blue Cross Blue Shield	1-866-755-2776	
Mail Order	Precision Rx	1-888-505-8361	www.precisionrx.com
Anthem Blue Vision Plan	Anthem Blue Cross Blue Shield	1-800-828-3677	

For additional information, contact askHR at 574-631-5900

Monthly Rates for 2009 Retiree Benefits

MEDICAL PLANS

PRE-MEDICARE PLANS (Under age 65)

Pre-Medicare Plans	Retiree	Retiree and Spouse
Meritain PPO	\$349.50	\$699.00
Meritain CHA HMO	\$354.00	\$701.25
Meritain Select HMO	\$285.75	\$571.50

Note: Rates include medical and prescription coverage.

MEDICARE PLAN (Over age 65)

Medicare Plan	Retiree	Retiree and Spouse
Anthem Blue Traditional \$250 with Medicare Part D (RX)	\$238.00	\$476.00

Note: Rates include medical, prescription, and vision coverage.

**PRE-MEDICARE
PLANS
UNDER AGE 65**

DEFINITIONS TO HELP YOU UNDERSTAND YOUR PRE-MEDICARE PROGRAMS

Preferred Provider Organization (PPO):

An organization that establishes contracts with a network of physicians and hospitals to provide health care services to enrolled members at a predetermined fee. PPO members must pay additional fees for utilizing services outside the network.

Health Maintenance Organization (HMO):

An organization that contracts with individuals, employers, physicians, and the government to provide comprehensive health care services to enrolled members at a set fee, per member, per month.

In-network:

Physicians who participate in the correlating medical plan network, are local providers, and have contracted with the insurance company providing medical coverage.

Co-payment:

A flat, per-service fee that is paid upfront by the retiree for services such as physician office visits.

Co-insurance:

Your share of eligible expenses

Deductible:

The dollar amount that must be paid each year by the retiree before the medical plan begins to pay benefits for certain covered expenses.

MEDICAL PLAN - ENHANCEMENTS FOR 2009

MERITAIN PPO

Hearing Aid Benefit *New!*

After the deductible and coinsurance have been applied/met, the plan will pay up to \$1,500 of the reasonable and customary charges for fittings, approved hearing correction devices and the first set of batteries for hearing aids every 36 months. All services must be provided by an audiologist or certified hearing aid specialist and recommended or prescribed by a physician. The Plan will not pay for over-the-counter hearing aids, repair of broken aids, lost aids, or for replacement batteries.

Marriage counseling will be covered under the mental health benefit. *New!*

MERITAIN SELECT HMO AND CHA HMO

Mental Health and Substance Abuse out-patient office visits will increase from 20 visits to 50 visits per calendar year, per member when medically necessary. This benefit will now also include marriage counseling. Please note that the annual 50 office visits allowed combines mental health, substance abuse and marriage counseling.

Occupational Therapy visits will increase from 20 visits to 50 visits per calendar year, per member when medically necessary.

Speech Therapy visits will increase from 20 visits to 50 visits per calendar year, per member when medically necessary.

Hearing Aid Benefit *New!*

The Plans will pay 100% up to \$1,500 of the reasonable and customary charges for fittings, approved hearing correction devices and the first set of batteries for hearing aids every 36 months. All services must be provided by an audiologist or certified hearing aid specialist and recommended or prescribed by a physician. The Plans will not pay for over-the-counter hearing aids, repair of broken aids, lost aids or for replacement of batteries.

PRE-MEDICARE PLANS (Under Age 65)

PRE-MEDICARE PLANS

The University offers three types of Pre-Medicare Plans:

- Meritain PPO
- Meritain CHA HMO
- Meritain Select HMO

HOW THE PLANS WORK

Meritain PPO Plan

If you are a Meritain PPO plan participant, your coverage includes both in-network and out-of-network services with a \$400 individual deductible for in-network services and an \$800 individual deductible for out-of-network services. Once you have met your deductibles, in-network services are covered at 85% and out-of-network services are covered at 65%. The Meritain PPO provides nationwide coverage for both routine and emergency medical care.

The Meritain PPO offers you the flexibility to visit physicians both in-network and out-of-network. The plan does not require you to choose a primary care physician.

Meritain CHA HMO & Meritain Select HMO

Both HMO provide plan participants with local, in-network coverage as well as life-threatening emergencies that may occur while out of the in-network area. Situations requiring immediate medical attention are considered life-threatening emergencies, while routine medical care is not. Most of the time plan coverage is based on co-payments.

Meritain CHA HMO does not require plan participants to designate a primary care physician nor do they require referrals from a primary care physician to visit specialist physicians in the Community Health Alliance (CHA) Network. Co-payments for CHA physician office visits are as follows:

- \$20 for primary care
- \$30 for specialist

For this plan, the following health care professionals will be considered as primary care physicians: family and general practitioners, internists, pediatricians, and Ob-Gyn physicians. Specialists must be listed in the CHA directory. If not, prior approval is required through Utilization Management.

Meritain Select HMO does not require plan participants to designate a primary care physician nor do they require referrals from a primary care physician to visit specialist physicians in the Select Network. Co-payments for Select physician office visits are as follows:

- \$20 for primary care
- \$30 for specialist

For this plan, the following health care professionals will be considered as primary care physicians: family and general practitioners, internists, pediatricians, and Ob-Gyn physicians. Specialists must be listed in the Select directory. If not, prior approval is required through Utilization Management.

PRE-MEDICARE PROGRAMS COMPARISON CHART

When you are deciding which program to choose, there are a number of factors to consider. Because each medical option has unique features, it is important for you to take a few moments to review the chart on the following pages to gain a better understanding of the differences among the medical plans.

Summary of Early Retirement Plans (Under Age 65)

Plan Coverage	Meritain PPO	Meritain Select HMO	Meritain CHA HMO
In-Network Hospital	St. Joseph Regional Medical Center, Goshen, LaPorte & Lakeland	St. Joseph Regional Medical Center, Goshen, LaPorte & Lakeland	Memorial Hospital and Elkhart General Hospital
Provider Network	Select Health (Local Network) Beech Street (National Network) New Avenues (Midwest Behavioral Health Network)	Select Health New Avenues (Midwest Behavioral Health Network)	Community Health Alliance (CHA) Network
Deductible	<u>In-Network:</u> \$400 (Individual) \$800 (Family) <u>Out-of-Network:</u> \$800 (Individual) \$1600 (Family) In and out-of-network deductibles do not cross accumulate	For In-patient Hospital Services Only \$350 (Individual) \$700 (Family)	For In-patient Hospital Services Only \$350 (Individual) \$700 (Family)
Co-Insurance (Your share of eligible expenses.)	<u>In-Network:</u> 85% of eligible charges after deductible. (Employee pays remaining 15%.) <u>Out-of-Network:</u> 65% of eligible, reasonable, and customary charges after deductible. (Employee pays remaining 35% plus any amounts above reasonable & customary.)	For In-patient Hospital Services Only 85% of eligible charges after inpatient deductible. (Employee pays remaining 15%)	For In-patient Hospital Services Only 85% of eligible charges after inpatient deductible. (Employee pays remaining 15%)
Out-of-Pocket Limits Includes the annual deductible (Note: Once the out-of-pocket limit is met on an annual basis, the plan pays 100% of eligible charges. No one family member can meet this limit for the whole family.)	<u>In-Network:</u> \$1250 (Individual) \$3000 (Family) <u>Out-of-Network:</u> \$2500 (Individual) \$5000 (Family) In and out-of-network deductibles do not cross accumulate	For In-patient Hospital Services Only \$800 (Individual) \$1,600 (Family)	For In-patient Hospital Services Only \$800 (Individual) \$1,600 (Family)
Physician Office Visits (Co-payments)	<u>In-Network:</u> 100% after \$20 co-payment per physician office visit. The co-payment is required even after deductible is met. <u>Out-of-Network:</u> 65% of eligible, reasonable, and customary charges after annual deductible. (Employee pays 35% plus any amounts above reasonable & customary.)	100% after \$20 co-payment per primary care physician office visit. (Family and General Practitioner, Internist, Pediatrician, or OB/GYN). 100% after \$30 co-payment per specialist physician office visit.	100% after \$20 co-payment per primary care physician office visit. (Family and General Practitioner, Internist, Pediatrician, or OB/GYN). 100% after \$30 co-payment per specialist physician office visit.

This chart does not replace the legal plan documents or contracts for each of the benefit plans and should not, in any way, be considered a contract.

Plan Coverage	Meritain PPO	Meritain Select HMO	Meritain CHA HMO
Allergy testing	<u>In-Network</u> 85% after deductible <u>Out-of-Network:</u> 65% after deductible	100% after \$30 co-payment per specialist physician office visit.	100% after \$30 co-payment per specialist physician office visit.
Allergy treatment	<u>In-Network</u> \$20 co-pay <u>Out-of-Network</u> 65% after deductible	\$20 co-pay PCP 100% after \$30 co-payment per specialist physician office visit	\$20 co-pay PCP 100% after \$30 co-payment per specialist physician office visit
Ambulance	<u>In-Network & Out-of-Network</u> 85% after deductible	No charge for service (from area first disabled) to nearest facility qualified to provide care when medically necessary and approved by the Plan.	No charge for service (from area first disabled) to nearest facility qualified to provide care when medically necessary and approved by the Plan.
Children Eligibility	Children are eligible until age 19 as long as dependent on employee for at least 50% of financial support. If children are full-time students (at least 12 credit hours) and unmarried, they remain eligible until age 25. Their coverage ends at the end of the calendar month in which they lose eligibility.	Children are eligible until age 19 as long as dependent on employee for at least 50% of financial support. If children are full-time students (at least 12 credit hours) and unmarried, they remain eligible until age 25. Their coverage ends at the end of the calendar month in which they lose eligibility.	Children are eligible until age 19 as long as dependent on employee for at least 50% of financial support. If children are full-time students (at least 12 credit hours) and unmarried, they remain eligible until age 25. Their coverage ends at the end of the calendar month in which they lose eligibility.
Chiropractic Care	<u>In-Network</u> \$20 co-pay <u>Out-of-Network</u> 65% after deductible	\$20 co-pay (20 annual visits)	\$20 co-pay (20 annual visits)
Diabetic Supplies Covered as part of the Prescription Drug Program	N/A	N/A	N/A
Durable Medical Equipment	<u>In-Network:</u> 85% of eligible charges up to annual maximum after deductible. <u>Out-of-Network:</u> 65% of eligible, reasonable, and customary charges after deductible up to annual maximum. Annual maximum of \$15,000 per person/per year.	Covered in full with prior approval from Meritain Health.	Covered in full with prior approval from Meritain Health.
Emergency Services (Out-of-Area/Out-of-State)	85% after deductible. If you are out of the area at the time emergency treatment is required and it is not life threatening, visit the Beech Street web site at www.beechstreet.com or call 1-800-432-1776 to locate the nearest network provider.	If you have a medical emergency and your medical condition is dangerous or life threatening, you should go to the nearest medical facility for treatment (whether you are in the service area or out of the area). Contact Meritain Health to notify them of the emergency treatment. Routine medical care and non-emergency care received out of town is not covered.	If you have a medical emergency and your medical condition is dangerous or life threatening, you should go to the nearest medical facility for treatment (whether you are in the service area or out of the area). Contact Meritain Health to notify them of the emergency treatment. Routine medical care and non-emergency care received out of town is not covered.

Plan Coverage	Meritain PPO	Meritain Select HMO	Meritain CHA HMO
	If the medical emergency turns into an inpatient hospital admission, the physician or employee should contact Meritain Health within 48 hours to request pre-certification.	If the medical emergency turns into an inpatient hospital admission, the physician or employee should contact Meritain Health within 48 hours to request pre-certification.	If the medical emergency turns into an inpatient hospital admission, the physician or employee should contact Meritain Health within 48 hours to request pre-certification.
Emergency Services (In-Area)	<p>Emergency Services (In-Area)</p> <p>85% after deductible.</p> <p><u>Out-of-Network:</u> 65% after deductible of eligible, reasonable and customary charges.</p> <p>\$50 co-payment for services provided at Select's Urgent Care Centers</p>	<p>\$120 co-payment for Emergency Room (waived if patient is admitted).</p> <p>\$40 co-payment for services provided at Selects Urgent Care Centers</p>	<p>\$120 co-payment for Emergency Room (waived if patient is admitted).</p> <p>\$40 co-payment for Urgent Care provided at Medpoint and other CHA Urgent Care providers.</p> <p>\$25 co-pay for Urgent Care at Medpoint Express</p>
Genetic Testing	Not Covered	Not Covered	Not Covered
Hospital Room & Board (Benefits are provided up to the semi-private room rate)	<p><u>In-Network:</u> 85% after deductible.</p> <p><u>Out-of-Network:</u> 65% after deductible of eligible, reasonable and customary charges.</p>	85% after annual inpatient deductible.	85% after annual inpatient deductible.
Laboratory & X-Ray	<p><u>In-Network:</u> 85% after deductible.</p> <p><u>Out-of-Network:</u> 65% after deductible of eligible, reasonable and customary charges.</p>	100%	100%
Maternity (No pre-existing conditions apply)	<p><u>In-Network:</u> Maternity benefits are administered under a global fee charge at the time of delivery, including ante-partum care (doctor visits prior to delivery), delivery services (vaginal delivery – with or without episiotomy/forceps and caesarian delivery), and postpartum care (hospital and office visits following delivery). \$20 co-payment may not be required at each office visit. Subject to annual deductible and paid at 85%. Memorial Hospital Mother and Child Care Center and Neonatal Nursery are included as in-network services.</p> <p><u>Out-of-Network:</u> Pre-natal and post-natal office visits and delivery. Subject to annual deductible and paid at 65%. Baby needs to be enrolled within 31 days of birth.</p>	<p>100% after \$20 co-payment per office visit.</p> <p>100% after \$30 specialist co-pay per office visit</p> <p>Delivery fee: 85% after inpatient deductible. A single hospital deductible-payment applies for mother and child providing mother and child are discharged at the same time.</p> <p>Maternity benefits are administered under a global fee charge at the time of delivery, including ante-partum care (doctor visits prior to delivery), delivery services (vaginal delivery – with or without episiotomy/forceps and caesarian delivery), and postpartum care (hospital and office visits following delivery).</p> <p>Baby needs to be enrolled within 31 days of birth.</p>	<p>100% after \$20 co-payment per office visit.</p> <p>100% after \$30 specialist co-pay per office visit</p> <p>Delivery fee: 85% after inpatient deductible. A single hospital deductible-payment applies for mother and child providing mother and child are discharged at the same time.</p> <p>Maternity benefits are administered under a global fee charge at the time of delivery, including ante-partum care (doctor visits prior to delivery), delivery services (vaginal delivery – with or without episiotomy/forceps and caesarian delivery), and postpartum care (hospital and office visits following delivery).</p> <p>Baby needs to be enrolled within 31 days of birth.</p>

Plan Coverage	Meritain PPO	Meritain Select HMO	Meritain CHA HMO
Mental Health Services (In-patient)	<p><u>In-Network:</u> 85% after annual deductible for physician (M.D., Ph.D., and Licensed Clinical Social Worker) services. Limited to 60 days per calendar year (less in-patient alcoholism/drug abuse days used).</p> <p><u>Out-of-Network:</u> 65% after annual deductible for physician (M.D., Ph.D., and Licensed Clinical Social Worker) services. Limited to 60 days per calendar year (less in-patient alcoholism/drug abuse days used).</p> <p>A Meritain Clinical Case Manager will determine medical necessity and duration in collaboration with your therapist.</p>	<p>85% after annual in-patient deductible. (M.D., Ph.D., and Licensed Clinical Social Worker). Limited to 60 days per member per calendar year (less in-patient alcoholism/drug abuse days used).</p> <p>A Meritain Clinical Case Manager will determine medical necessity and duration in collaboration with your therapist.</p>	<p>85% after annual in-patient deductible. (M.D., Ph.D., and Licensed Clinical Social Worker). Limited to 60 days per member per calendar year (less in-patient alcoholism/drug abuse days used).</p> <p>A Meritain Clinical Case Manager will determine medical necessity and duration in collaboration with your therapist.</p>
Mental Health Services (Out-patient) Beginning January 1, 2009 marital counseling will now be covered.	<p><u>In-Network:</u> 85% after annual deductible for physician (M.D., Ph.D., and Licensed Clinical Social Worker) services. (Services are not considered the same as routine office visit and do not qualify for payment at 100% after a \$20 co-payment.) Limited to 50 visits per calendar year (less out-patient alcoholism/drug abuse visits used).</p> <p><u>Out-of-Network:</u> 65% after annual deductible for physician (M.D., Ph.D., and Licensed Clinical Social Worker) services. Limited to 50 visits per calendar year (less out-patient alcoholism/drug abuse visits used).</p>	<p>Covers short-term crisis and acute symptoms or impairment stabilization. 100% after \$30 co-payment for physician services (M.D., Ph.D., and Licensed Clinical Social Worker) per office visit. Limited to 50 visits per calendar year per member when medically necessary (less out-patient alcoholism/drug abuse visits used.)</p>	<p>Covers short-term crisis and acute symptoms or impairment stabilization. 100% after \$30 co-payment for physician services (M.D., Ph.D., and Licensed Clinical Social Worker) per office visit. Limited to 50 visits per calendar year per member when medically necessary (less out-patient alcoholism/drug abuse visits used.)</p>
Physical Therapy	<p><u>In-Network:</u> 100% after \$20 co-payment per visit.</p> <p><u>Out-of-Network:</u> 65% after deductible.</p> <p>Treatment plans including frequency and duration are required from the provider.</p>	<p>100% after \$20 co-payment per office visit for up to 50 outpatient visits.</p> <p>Treatment plans including frequency and duration are required from the provider.</p>	<p>100% after \$20 co-payment per office visit for up to 50 outpatient visits.</p> <p>Treatment plans including frequency and duration are required from the provider.</p>
Prescription Drugs	Note: Automatically enrolled when medical coverage with Notre Dame is elected. Prescription Drug benefits are administered by Medco.		
Preventive Care	Age 7 and Older - Coverage for In-Network Only	No Age Limit - Coverage for In-Network Only	No Age Limit -Coverage for In-Network Only
- physical exam	All eligible services are covered at 100%, no co-payment, 1 per year.	All eligible services are covered at 100%, no co-payment, 1 per year.	All eligible services are covered at 100%, no co-payment, 1 per year.

Plan Coverage	Meritain PPO	Meritain Select HMO	Meritain CHA HMO
- well women care (includes PAP smear)	All eligible services are covered at 100%, no co-payment, 1 per year.	All eligible services are covered at 100%, no co-payment, 1 per year.	All eligible services are covered at 100%, no co-payment, 1 per year.
- mammogram	Baseline at age 35; 1 per year after age 40.	Baseline at age 35; 1 per year after age 40.	Baseline at age 35; 1 per year after age 40.
- blood screening (plus blood pressure/height and weight)	1 per year.	1 per year.	1 per year.
- sigmoidoscopy	1 per year after age 50.	1 per year after age 50.	1 per year after age 50.
- occult blood	1 per year after age 40.	1 per year after age 40.	1 per year after age 40.
- prostate -specific antigen (PSA)	1 per year after age 50.	1 per year after age 50.	1 per year after age 50.
- Immunizations - Recommended Immunizations (Department of Health & Human Services - Center for Disease Control & Prevention) in the schedule of Benefits Table.	These immunizations are to be covered for all members that meet the appropriate age requirements for the immunizations.	These immunizations are to be covered for all members that meet the appropriate age requirements for the immunizations.	These immunizations are to be covered for all members that meet the appropriate age requirements for the immunizations.
Preventive Care – (Children) <ul style="list-style-type: none"> • Periodic Well Care Check-ups • Well Baby Care • Immunizations/ Inoculations 	Under Age 7 <u>In-Network:</u> All eligible services are covered 100%, no co-payment. <u>Out-of-Network:</u> Subject to deductible and 65% coinsurance. (State mandated immunizations are covered at any age.)	No age limit– Coverage for In-Network Only All eligible services are covered 100%, no co-payment.	No age limit– Coverage for In-Network Only All eligible services are covered 100%, no co-payment.
Surgery/In-patient	<u>In-Network:</u> 85% after deductible. <u>Out-of-Network:</u> 65% after deductible of eligible, reasonable, and customary charges.	85% after annual in-patient deductible.	85% after annual in-patient deductible.
Surgery/Out-patient (office)	<u>In-Network:</u> 85% after deductible. (Services are not considered the same as a routine office visit and do not qualify for payment at 100% after a \$20 co-payment.) <u>Out-of-Network:</u> 65% after deductible.	100% after \$100 co-payment per procedure for out-patient surgery.	100% after \$100 co-payment per procedure for outpatient surgery.
Voluntary Abortion and/or Sterilization	Not Covered	Not Covered	Not Covered

Visit www.hr.nd.edu/benefits for complete plan documents.

Women’s Health & Cancer Rights Act Enrollment Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women’s Health and Cancer Rights Act of 1988. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce symmetrical appearance; prostheses
- Treatment of physical complications of the mastectomy, including lymphedemas

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

Prescription Drug for Pre-Medicare Plans

Medco

You are automatically enrolled in the prescription drug plan administered by Medco when you enroll in one of the medical options.

The **prescription drug** plan provides retail and mail services. Under the retail network service, you can visit any in-network pharmacy for your short-term prescription drug needs. For a 30-day drug supply, the following co-payments apply:

- \$5 for generic drugs
- \$20 for preferred brands
- \$35 for non-preferred brands
- \$70 for specialty drugs

If you visit an out-of-network pharmacy, you must pay the prescription drug cost in full and then file a claim for reimbursement. Medco will reimburse the cost of the prescription drug minus the applicable co-payment.

The **mail service** program must be used for maintenance or long-term medications. This will

save you time and money, as you will receive a 90-day supply delivered to your home for the following co-pays:

- \$12 for generic drugs
- \$45 for preferred brands
- \$75 for non-preferred brands
- \$150 for specialty drugs

Medco offers participants several online services such as :

- Benefit plan information
- Coverage comparisons on home delivery, retail brand-name, and generic medications
- Online prescription orders, tracking prescription status, and viewing up to 18 months of prescription history.

For more information about Medco, visit www.medco.com

Helpful Definitions

GENERIC DRUGS VS. BRAND-NAME DRUGS

Generic Drugs: Generic drugs are identical to brand name drugs but are sold under their chemical generic name. Generic drugs must contain the same active chemical ingredients and be equivalent in strength and dosage to the brand-name product. Generic drugs are regulated by the Federal Food and Drug Administration to ensure the quality, strength, and purity of generic drugs.

Brand-Name Drugs: Brand-name drugs are drugs that are advertised and sold under a product name chosen by the manufacturer. In general, brand-name drugs are more expensive than generic drugs.

Specialty Drugs - Self injectable medications dispensed by Specialty Pharmacy.

What is a Formulary?

A formulary is a cost-effective solution to help you select prescription drugs for you and your family. The formulary is a continually updated list of preferred drugs selected by a panel of physicians and pharmacists. A drug on the formulary benefits members as it gives them access to valuable medications at a lower co-payment. Both generic and brand drugs that provide effective, safe, and appropriate drug therapies are listed on the formulary.

Frequently Asked Questions: Pre-Medicare Plans

Question	Answer
What does “in-network mean?”	An in-network provider is a physician, facility, or other provider that has agreed to supply covered services to their members at a reduced or negotiated rate.
What does “out-of-network” mean?	An out-of-network provider is a physician, facility, or other provider that has not contracted with the selected medical plan and may charge participants higher or non-negotiated rates.
How can I find a provider directory?	<p>Visit one of the following websites for the applicable provider directory:</p> <ul style="list-style-type: none"> • Select Health Network (local) www.selecthealthnetwork.com • Beech Street Network (national) www.beechstreet.com • CHA Network (local) www.chanetwork.com • Medco Health (prescription) www.medco.com • New Avenues (behavioral health) www.newavenuesonline.co
Meritain PPO	
How do I contact Meritain?	Meritain has established a dedicated toll free number for retirees of Notre Dame. This number is 1-888-668-6855. Customer service representatives are available Monday-Friday, 8:00 a.m. - 5:00 p.m. EST. Information regarding claims can also be obtained on their website at www.meritainhealth.com .
What is Utilization Management?	Utilization Management is the department that handles prior authorizations and pre-certifications.
Who should I contact for Utilization Management?	Meritain also handles utilization management. The toll free number for utilization management is 1-800-242-1199. This number will also be listed on your identification card.
When should I contact Utilization Management?	Utilization management should be contacted before you or a covered family member is admitted to the hospital. In the case of a life-threatening emergency, NAA must be notified within 48 hours or the first business day following hospital admission.
What networks are associated with the Preferred Provider Organization Plan?	The Preferred Provider Organization (PPO) will be utilizing three networks. The local network is Select Health Network, the national network is Beech Street Network, and the behavioral health network is New Avenues Midwest.

Question	Answer
How do I locate a provider in the Select Health Network?	You can log onto their website at www.selecthealthnetwork.com or use a paper directory, which is available in the Office of Human Resources.
How do I locate a provider in the Beech Street Network?	Beech Street can be contacted by phone at 1-800-432-1776 or online at www.beechstreet.com . You can use this contact information to verify network participation or to request doctors who currently are not affiliated.
How do I locate a mental health provider?	New Avenues (Midwest Behavioral Health Network) can be contacted at 1-800-223-6246 or online at www.newavenuesonline.com .
Meritain CHA and Select HMO	
How do I contact Meritain?	Meritain has a dedicated toll free number for retirees of Notre Dame. This number is 1-888-668-6855. Customer Service representatives are available Monday-Friday, 8:00 a.m. -5:00 p.m. EST. Information regarding claims can also be obtained on their website at www.meritainhealth.com .
What is Utilization Management?	Utilization Management is the department that handles prior authorizations and pre-certifications.
Who should I contact for Utilization Management?	You will need to contact the number on the back of your insurance card.
When should I contact Utilization Management?	Utilization Management should be contacted before you or a covered family member is admitted to the hospital. In the case of a life-threatening emergency, Meritain must be notified within 48 hours or the first business day following hospital admission.
What health professionals require a \$20 co-payment?	Family and general practitioners, internists, pediatricians and Ob-Gyn physicians.
When is a \$30 co-payment required?	When you visit specialist physicians other than those listed above.
What network does the Meritain CHA HMO use?	Meritain CHA HMO will be accessing Community Health Alliance (CHA) for the in-network benefit.
How do I locate a provider in the Community Health Alliance Network?	You can visit their website at www.chanetwork.com or call 1-574-284-1025 or 1-888-689-2242. A paper directory will be available in the Office of Human Resources.
What networks are associated with the Select HMO Plan?	The Select HMO Plan will be utilizing two networks. The local network is Select Health Network and the behavioral health network is New Avenues Midwest.
How do I locate a provider in the Select Health Network?	You can log onto their website at www.selecthealthnetwork.com or use a paper directory, which is available in the Office of Human Resources.

Pharmacy

Question	Answer
Which pharmacies can I use?	You can log onto www.medco.com to find out whether a particular pharmacy is in the network.
How will I get started using the mail service pharmacy?	<p>If you are using the mail service for the first time, requesting a new prescription for home delivery is simple whether you are ordering my mail, fax, or online. Just follow these steps:</p> <p>By Mail:</p> <p>Step 1: Ask your doctor to write a new prescription for up to a 90-day supply, plus refills (if appropriate) for up to 1 year.</p> <p>Step 2: Mail the new prescription(s), along with the “Ordering Medications” form and the appropriate co-payment, to Medco in the return envelope.</p> <p>By Fax:</p> <p>Step 1: Ask your doctor to write a new prescription for up to a 90-day supply, plus refills (if appropriate) for up to 1 year. Give your doctor your member ID number, which is on your prescription ID card.</p> <p>Step 2: Ask your doctor to call 1-888-EASYRX1 (1-888-327-9791). Your doctor will receive directions for faxing your prescription to Medco, and you will be billed later.</p> <p>Online:</p> <p>You can request new prescriptions online by visiting www.medco.com.</p> <p>Step 1: If you haven’t already done so, take a few moments to register with Medco, making sure you let them know that you are a Medco plan member when prompted. Once you are registered, all you need to do when you return is log in using the email address and password you created.</p> <p>Your medication will be delivered to your home within 7 to 11 days after you mail your order. Orders placed via the internet, telephone, or fax may be received even faster. Standard shipping is free.</p>

HIPAA NOTICE OF AVAILABILITY

The Privacy Rule under The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires health plans to remind covered participants of the availability of the Privacy Notice and how they can obtain it.

The Notice of Privacy Practices for the University of Notre Dame’s Flex Plan describes the uses and disclosures of your protected health information and your rights regarding them.

A copy of The Notice of Privacy Practices for the University of Notre Dame’s Flex Plan can be obtained by:

- Visiting the Human Resources website at: <http://hr.nd.edu/benefits/privacypractices.shtml>
- Contacting the askHR Customer Service Center at: 574-631-5900
- Email: askhr@nd.edu
- Visiting Shared Services in the Office of Human Resources, Grace Hall, Second Floor

MEDICARE PLAN AGE 65 & OVER

Important Information Regarding Enrollment

You will not need to enroll in Medicare Part D as long as you enroll in the retiree insurance with Notre Dame. The prescription coverage through Anthem is greater than that offered by the standard Medicare Part D Drug Plan.

IMPORTANT NOTICE FROM THE UNIVERSITY OF NOTRE DAME ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Notre Dame and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Notre Dame has determined that the prescription drug coverage offered by Anthem is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15th through December 31st.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Retiree Medical Plan coverage through Notre Dame (Anthem Blue Medicare RX) coverage will be affected.

If you do decide to join a Medicare drug plan and drop your current Notre Dame medical/prescription drug coverage, be aware that you and your dependents will not be able to get this coverage back. You cannot be enrolled in two Medicare Part D plans.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Notre Dame/Anthem Blue Traditional/Anthem Blue Medicare RX and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Notre Dame's medical/prescription drug plan changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	10/31/2008
Name of Entity/Sender:	University of Notre Dame
Contact-Position/Office:	Denise Murphy
Address:	200 Grace Hall; Notre Dame IN 46556
Phone Number:	574-631-5900

Medicare Plan (Age 65 and Over)

The Medicare Plan has two components: the medical plan is called the Anthem Blue Traditional \$250 and the prescription drug plan is called Precision Rx.

ANTHEM BLUE TRADITIONAL \$250 (Medical Services)

Covered Benefits	Retiree's Responsibility
Deductible (Individual/Family) Applies only to {percent co-payments}	\$250/\$500
Out-of-Pocket Maximum (Individual /Family)	\$2500/\$5000
Percentage Co-payments	20%
Physician Office Visits (Including outpatient mental health and substance abuse in a physician office)	20%
Routine/Preventative	Covered in full (not subject to deductible) up to \$500 per person per calendar year.
Maternity Services	20%
Outpatient Therapy Visit Limits	
Physical/Occupational	Unlimited Visits
Spinal Manipulation	Unlimited Visits
Speech	Unlimited Visits
Mental Health/Substance Abuse	Covered as any other illness. Subject to same co-pays, deductibles and maximums.
Lifetime Maximum	\$1 million (excluding human organ and tissue transplants)
Human Organ and Tissue Transplants	Covered in full at designated transplant facility/50% non-designated facility co-payment (Does not count toward out-of-pocket maximum)

Notes:

- Dependent age: to end of calendar year of age 19; age 24 if dependent qualifies as full-time student
- Attention Deficit Disorder is excluded after diagnosis (except for prescription drugs).
- The deductible and co-pays apply toward the out-of-pocket maximums, except where indicated
- Certain diabetic and asthmatic supplies are covered in full at network pharmacies

Covered in full option applies to the following services: inpatient services (facility, ancillary, and professional), surgery – all places of service, outpatient facility except physical medicine therapies, maternity services, inpatient services and outpatient facilities services for mental health and substance abuse, emergency care in emergency room, hospice services, radiation, chemotherapy, cardiac rehab, dialysis, inhalation therapy, ambulance (\$4000 maximum per member per calendar year), diagnostic services – including MRI (excludes services stated under preventative care services). **Excludes all** abortions unless spontaneous or life of mother is threatened, excludes sterilizations unless medically necessary, excludes all forms of contraceptives and contraceptive devices.

Human organ and tissue transplants (except kidney and cornea) are covered in full at a designated transplant facility: 50% at a non-designated facility. Does not count toward the out-of-pocket maximum. Subject to a separate \$1 million lifetime maximum.

Preventive Care Benefits: Routine or periodic exams including physical exams and immunizations required for travel, pelvic exams, routine EGB, chest X-rays, laboratory tests such as complete blood count, comprehensive metabolic panel, urine analysis, annual dilated eye exam for diabetic retinopathy. Screening exams for mammograms, routine cytologic and Chlamydia screening (including pap tests); routine bone density testing for women, routine prostate specific antigen testing, routine colorectal cancer exam and related lab tests.

Preventive Care, Hearing and Vision (Not Medicare eligible): The following services are covered on an annual basis and are limited to the \$500 Calendar year maximum:

- Physical Exams (Based on Usual and Customary-foot care is not covered)
- Hearing Exams (Hearing aids not covered)
- Vision Exams (Not Medicare eligible)
 - o If Anthem Blue Vision Provider is Selected
 - o \$5 co-pay on Exam
 - o 20% discount on frames and lenses
 - o 15% discount on contact lenses

Routine/Preventive: When covered, charges are paid at 100% with no deductible up to the limits specified. Medicare will not cover routine physical exams, lab tests. To be reimbursed:

- a. Complete a Major Medical claim form (AIN-300).
- b. Make a copy of the claim form and the billing from the provider.
- c. Send the claim form and a copy of the billing to Anthem Blue Cross and Blue Shield at the address on the back of your ID card.

Routine Mammograms, Pap Smears and PSA Tests—Since Medicare will pay for these tests on different intervals, always ask the provider of service to file these tests with Medicare first. If the service is not eligible, Medicare will reject. Once that happens and you receive your Medicare Explanation of Benefits showing the claim was not paid:

- a. Complete a Major Medical claim form (AIN-300).
- b. Make a copy of the claim form, provider itemized statement and a copy of the Medicare Claim Summary for your records.
- c. Send the claim form, a copy of the Medicare Claim Summary and the provider itemized statement to Anthem Blue Cross and Blue Shield at the address on the back of your ID card.

ANTHEM BLUE VISION PLAN

This summary outlines the vision benefits available to you through the Anthem Blue Vision Exam Plus Discount plan. Please review your benefit certificate for plan details, eligibility definitions, limitations and exclusions.

Anthem's Provider Network: For Anthem Vision provider locations, you may access the provider directory at www.anthem.com. You can also contact Anthem Blue Vision customer service by calling the number listed on your ID card or 800.828.3677 in Indiana. Schedule an appointment with your Anthem Vision provider. Identify yourself as an Anthem member for fast, paperless determination and confirmation of benefits. Anthem Vision providers must be used to obtain benefits and discounts.

Savings: Through the Anthem Blue Vision Exam Plus Discount plan, Anthem Vision providers agree to a pricing that is listed below retail. Members are able to achieve savings on purchases of frames, lenses and contact lenses.

Co-payment(s): Co-payment amounts are applicable to Network provider examinations

COVERED BENEFITS	MEMBER BENEFIT FROM ANTHEM VISION NETWORK PROVIDER	NON-NETWORK REIMBURSEMENT*
Vision Examination Each member is entitled to a vision examination by an Anthem Vision provider. This vision examination does not cover a separate contact lens professional fitting fee. Availability: Once every 12 months*	\$5 co-payment	Not covered
Materials <ul style="list-style-type: none"> • Prescription lens and frames • Contact lenses 	Available at discount	Not covered

*Benefits are available from the last date of service.

Vision Claims (You must select an Anthem Blue Vision Provider or no benefits are available)

- a. Select an Anthem Blue Vision provider.
- b. Call for an appointment.
- c. You will be responsible for your \$5 co-pay and any charges for discounted frames and lenses. The Anthem Blue Vision provider will file your exam visit with Anthem.

Medical Customer Service Phone Number: 1-800-280-7293
 Vision Customer Service Phone Number: 1-800-828-3677

BLUE MEDICARE RX PLAN DESCRIPTION

With Blue MedicareRX You Pay	\$250 Deductible with 20% Coinsurance
A flat dollar amount (co-payment) or a percentage of the cost (coinsurance) for covered generic, brand or other prescription drugs, until the annual out-of-pocket of prescription drug expenses reaches \$2500. (This includes any deductible, co-payments or coinsurance.)	30-day Supply* \$250 deductible with 20% coinsurance Generic/Formulary Brand/Non-Formulary Brand (not on drug list)
	90-day Supply* Preferred Mail Order Pharmacy Same as above
	Retail 90-day Pharmacy Same as above
Annual out-of-pocket maximum	\$2500

Important Notes: All covered drugs are on formulary/drug list unless otherwise noted.

***Network and Non-network Pharmacies:** At non-network pharmacies, you will be responsible for the difference between the network pharmacy costs, in addition to your co-payment. This does not apply in emergency situations, or when you do not have adequate access to a network retail pharmacy.

Enjoy the Convenience of Extended Supplies: Many prescription drugs are available in a 90-day extended supplies, when appropriate. We offer extended supplies through Precision Rx. Or, avoid multiple trips to the pharmacy with Retail 90-day Pharmacies.

Covered: Rx drugs are based upon Medicare's formulary. Medicare's formulary changes every 3 months. To obtain an updated copy please visit www.anthem.com or call the phone number listed on the back of your Blue Medicare Rx ID card.

In Ohio, Anthem Blue Cross and Blue Shield is the trade name of Community Insurance Company. In Kentucky, Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Kentucky, Inc. In Indiana, Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc. Independent licensees of the Blue Cross and Blue Shield Association. Registered marks Blue Cross and Blue Shield Association.

FREQUENTLY ASKED QUESTIONS - MEDICARE

Question	Answer
<p>What are the Medicare premiums and coinsurance rates for 2009?</p>	<p>Medicare Premiums for 2009:</p> <p>Part A: (Hospital Insurance) Premium</p> <ul style="list-style-type: none"> <input type="checkbox"/> Most people do not pay a monthly Part A premium because they or a spouse has 40 or more quarters of Medicare-covered employment. <input type="checkbox"/> The Part A premium is \$244.00 for people having 30-39 quarters of Medicare-covered employment. <input type="checkbox"/> The Part A premium is \$443.00 per month for people who are not otherwise eligible for premium-free hospital insurance and have less than 30 quarters of Medicare-covered employment. <p>Part B: (Medical Insurance) Premium</p> <ul style="list-style-type: none"> <input type="checkbox"/> \$96.40 per month. If your income is above \$85,000 (single) or \$170,000 (married couple), then your Medicare Part B premium may be higher than \$96.40. <p>Medicare Deductible and Coinsurance Amounts for 2009:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Part A pays for inpatient hospital, skilled nursing facility, and some home health care. For each benefit period Medicare pays all covered costs except the Medicare Part A deductible (2009 = \$1,068) during the first 60 days and coinsurance amounts for hospital stays that last beyond 60 days and no more than 150 days. <input type="checkbox"/> For each benefit period you pay: <ul style="list-style-type: none"> o A total of \$1,068 for a hospital stay of 1-60 days. o \$267 per day for days 61-90 of a hospital stay. o \$534 per day for days 91-150 of a hospital stay (Lifetime Reserve Days). o All costs for each day beyond 150 days <input type="checkbox"/> Skilled Nursing Facility Coinsurance <ul style="list-style-type: none"> o \$133.50 per day for days 21 through 100 each benefit period. <input type="checkbox"/> Part B covers Medicare eligible physician services, outpatient hospital services, certain home health services and durable medical equipment. <ul style="list-style-type: none"> o \$135.00 per year. (Note: You pay 20% of the Medicare-approved amount for services after you meet the \$135.00 deductible.) <p>For additional information about the Medicare premiums, deductibles, and coinsurance please also visit www.cms.gov. As of October 28, 2008 this information was taken from www.medicare.gov.</p>

FREQUENTLY ASKED QUESTIONS

Question	Answer
How do I file a claim (Blue Traditional \$250)?	<p data-bbox="649 256 1437 289"><u>University of Notre Dame Major Medical (Medicare eligible)</u></p> <ol data-bbox="743 298 1485 1123" style="list-style-type: none"><li data-bbox="743 298 1339 331">1. Have your provider file with Medicare.<li data-bbox="743 331 1485 514">2. If you reside in Indiana, the portion of the claim (deductible and co-insurance) not payable by Medicare will automatically be filed directly with Anthem Blue Cross and Blue Shield. This is called cross-over.<li data-bbox="743 514 1485 1123">3. If you reside outside of Indiana, ask your provider to follow the instructions on the back of your Identification Card. If the provider indicates they will not file with Anthem for your secondary benefits to be paid, once the Medicare Claim Summary (EMOB) is received:<ol data-bbox="841 751 1485 1123" style="list-style-type: none"><li data-bbox="841 751 1437 829">a. Complete a Major Medical claim form (number AIN-300).<li data-bbox="841 829 1437 934">b. Copy the Medicare Summary and the itemized billing from the provider and retain originals for your records.<li data-bbox="841 934 1485 1123">c. Send the copies of both the Medicare Summary and itemized billing to Anthem Blue Cross and Blue Shield at the address on the back of your Identification Card.

FREQUENTLY ASKED QUESTIONS: PRESCRIPTION DRUG PLAN - MEDICARE PART D

Question	Answer
I have heard that if I don't enroll in Medicare Part D now, I will be penalized if I try to enroll later. Should I sign up for a Medicare Part D plan?	If you have coverage with a group plan that offers the same or better benefits, you will not have to pay a higher premium if you decide to join Medicare Part D later. In your materials you have been provided a certificate that indicates the plan provided through Notre Dame is creditable coverage (the plan is as good as or better than Medicare Part D). Retain this certificate for future use in the event you have to join Medicare Part D at a later date and you will not be penalized.
What do I do if I have already enrolled with Medicare Part D?	You will want to contact Medicare to drop your Medicare Part D coverage.
Where can I get more information about Medicare Part D?	Go to http://www.medicare.gov/default.asp , and click on the Frequently Asked Questions.
Why won't the pharmacy ship my order if I have a balance due on my account?	Customers who have an outstanding balance on their account of \$20 or more will not have new prescription orders filled unless payment is received. If you submit a new prescription, it will be returned to you by mail. You will not be able to refill your prescriptions until the outstanding balance is paid.
If I have questions about my mail order, what telephone number do I call?	If you have questions about your mail order prescription, you can call Anthem toll-free at 1-800-962-8192, Monday – Friday, 8:30 a.m. to 5:00 p.m. Eastern Time. If you are hearing impaired, please call 1-800-221-6915.
How do I refill existing Precision Rx Direct Prescriptions?	Once your credit card number is on file, there are three simple ways you can refill existing Precision Rx Prescriptions: <ol style="list-style-type: none"> 1. Precision Rx automated phone line at 1-888-565-8361, Monday-Friday, 7:00 a.m. to 9:00 p.m. (CST) or Saturday, 8:00 a.m. to 7:00 p.m. 2. Precision Rx website: www.precisionrx.com 3. Mail in refill to Precision RX at: Precision Rx P.O. Box 961025 Fort Worth TX 76161-9863

Three Simple Ways to Refill Existing Precision Rx Prescriptions

By Phone:

1. Have your prescription label with doctor's name, phone number, and credit card (VISA, MasterCard or Discover) ready.
2. Call 1.888.565.8361. Press 0 to talk directly to a customer service representative. Representatives are available Monday through Friday, 7:00 a.m. to 9:00 p.m. and Saturday 8:00 a.m. to 7:00 p.m. EST.

By Internet: (Note: To protect your privacy, you must register to gain access to certain areas of the website – such as ordering refills.)

1. You can visit the Precision Rx web site at :
www.precisionrx.com
2. Submit a request for reorder over a secure connection paying with your credit card (VISA, MasterCard or Discover).

By Mail:

1. Call Anthem Rx to obtain the co-payment amount you will need to submit for the refill. The toll-free number is 1-800-962-8192, press 0 to talk directly to a customer service representative. (DO NOT call the toll-free number on your Anthem Blue Cross and Blue Shield Identification Card.)
2. Complete the upper portion of the form and attach the refill label in the area provided. If you need additional space, simply attach remaining refill labels to a sheet of paper. There is no need to complete another order form.
3. Place the completed form and your check made payable to Precision Rx in the self-addressed envelope and mail.
4. Your prescription will be mailed to the address you provide.

HELPFUL HINTS

If the prescription written is for a new medication, you might want to have the doctor write the first prescription for a 30-day supply to allow you to take the medication for a short period to determine if it is the correct medication for you. The doctor can provide a second prescription for up to a 90-day supply with 3 refills. Precision Rx will always fill your prescription with a generic equivalent unless you or your doctor indicates to fill the prescription with brand medications. You should discuss this with your doctor to determine if the generic equivalent is right for you.

