

Our plans fit your plans



• SmartSense®
• Premier



Our plans fit the way you live.

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

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

Experience you can rely on

As one of the most trusted names in health coverage, Anthem Blue Cross has been providing health care coverage and security to Californians for over 70 years. We're committed to simplifying your life and improving your health. In addition, we offer:

- **One of the largest provider networks in California.**
With nearly 60,000 PPO doctors and more than 350 hospitals throughout the state, chances are your doctor is one of ours. For a complete listing of all doctors in our network, go to anthem.com/ca and click on "Find a Provider".
- **A choice of plans to fit your budget and lifestyle.**
No matter where you are in life, we've got a plan designed to fit your health coverage needs, as well as your budget.
- **Optional dental and term life insurance.**
To enhance your health and your family's financial future, we also offer dental and term life coverage and make it easy to enroll.
- **Coverage that travels with you.**
No matter where life takes you, your health coverage goes with you. And the BlueCard® program makes it easy to access network providers across the country.

Why do you need health care coverage?

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

Some definitions so we're all on the same page

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

This is true whether you are paying the entire cost for covered services (such as while you are meeting your deductible), or whether we are sharing the cost. With nearly 60,000 doctors and specialists and more than 350 hospitals and other facilities, chances are your provider already participates. Just visit a network provider to take advantage of the savings.

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

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

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

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

Copayment (or Copay) is a specific dollar amount you have to pay for certain covered services.

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

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

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

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

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

Specialty Drugs are typically high cost, scientifically engineered drugs used to treat complex, chronic conditions. They require special handling and usually must be shipped directly to the user.

Formulary is a list of prescription drugs our health care plans cover. They include generic, brand name, and specialty drugs that have been rigorously reviewed and selected by a committee of practicing doctors and clinical pharmacists for their quality and effectiveness. We've negotiated lower prices on these formulary drugs, so you'll save when your doctor prescribes medication from our formularies. There can be different formularies for different health care plans.

SmartSense[®] Is this the right plan for you?

SmartSense was designed to offer affordable, solid protection without a lot of bells and whistles that may not be important to you.

SmartSense Plan Highlights

SmartSense offers affordable price options, solid protection that covers essentials and even some immediate benefits before the deductible.

Features:

- First three Doctors' Office Visits with predictable copays, per plan member, each calendar year before having to meet your deductible. This includes routine wellness visits or sick care.
- Choice of two prescription drug coverage options.
- \$7 million per member in lifetime benefits.

You should know:

- After first three Doctors' Office Visits, all other visits are covered after the deductible.
- Maternity benefits are not included with this plan.

SmartSense Preventive Care

With SmartSense, annual physical exams and certain preventive screenings (routine mammogram, Pap and PSA tests) and well-child services are covered after you meet your deductible. You also have the option of going to a HealthyCheckSM Center which provides immediate coverage for annual preventive screenings. For more information about HealthyCheckSM, go to anthem.com/healthycheck.

Prescription Drug Coverage

The cost of prescription drugs can be overwhelming, so SmartSense includes prescription drug coverage to help you manage those costs.

SmartSense prescription drug coverage includes the following tiers which represent a cost level within the generic and brand name prescription drug categories.

- **Drug Formulary:** This is a special list of prescription drugs the SmartSense plan covers. We've negotiated lower prices on these formulary drugs, so you'll save when your doctor prescribes from the Plan Formulary.
- **Tier 1:** These drugs have the lowest copay and include generic medications.
- **Tier 2:** These drugs have a higher copay than those in Tier 1 and include formulary brand name medications.
- **Tier 3:** These drugs have a higher copay than those in Tier 2 and include non-formulary brand name medications.
- **Specialty:** These are typically high-cost, scientifically engineered drugs and are paid at a coinsurance level instead of copay.

How to Customize your SmartSense Plan

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

Deductible: SmartSense plan deductibles range from \$500 to \$5,000. You can usually lower your premium by choosing a higher deductible. Simply choose the deductible and premium combination that works best for you.

Upgrade Drug Coverage: By choosing the Upgrade Drug Coverage option (for an additional cost) you can lower your prescription drug deductible to \$500, instead of the \$7,500 prescription drug deductible (for Tier 2, 3 and Specialty) included in the plan.

Other Optional Coverage: You can add more protection for you and your family by purchasing optional dental or life insurance. See the following pages for details.

Benefits

SmartSense®

Calendar Year Deductible

Your Choices

Individual	NETWORK:	\$500	\$1,500	\$2,500	\$5,000
	NON-NETWORK:	\$5,000	\$5,000	\$5,000	\$5,000
Family	NETWORK:	\$1,000	\$3,000	\$5,000	\$10,000
	NON-NETWORK:	\$10,000	\$10,000	\$10,000	\$10,000
Network Coinsurance Options		30%	30%	30%	30%

Calendar Year Out-of-Pocket Maximum

Add Your Chosen Deductible to the Amount Below

Individual	NETWORK:	\$2,500	\$2,500	\$2,500	\$2,500
	NON-NETWORK:	\$10,000	\$10,000	\$10,000	\$10,000
Family	NETWORK:	\$5,000	\$5,000	\$5,000	\$5,000
	NON-NETWORK:	\$20,000	\$20,000	\$20,000	\$20,000

How family deductibles and family out-of-pocket maximums work

Once one family member reaches their individual deductible or out-of-pocket maximum, the remaining amount of the family deductible or out-of-pocket maximum needs to be met by one or more other family members. The family deductible or out-of-pocket maximum can be met by the family combined.

Plan Lifetime Maximum

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

Covered Services

Your Share of Costs (after deductible, unless waived)

Doctors' Office Visits

NETWORK:
 • First 3 Office Visits (per member): **\$30 Copay**, deductible waived
 • Additional Office Visits: **30% Coinsurance**
NON-NETWORK: 50% Coinsurance

Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.)

NETWORK: 30% Coinsurance
NON-NETWORK: 50% Coinsurance

Inpatient Services (overnight hospital/facility stays)

NETWORK: 30% Coinsurance
NON-NETWORK: All charges except \$650 per day

Outpatient Services (without overnight hospital/facility stays)

NETWORK: 30% Coinsurance
NON-NETWORK: All charges except \$380 per day

Emergency Room Services

NETWORK: 30% Coinsurance plus \$100 Emergency Room copay (copay waived if admitted)
NON-NETWORK: 30% Coinsurance plus \$100 Emergency Room copay (copay waived if admitted)

Preventive Care Services

NETWORK:
 Annual physical exam: **30% Coinsurance**
 Routine mammogram, Pap and PSA tests: **30% Coinsurance**
 Well-Child (through age 6): **30% Coinsurance**
 HealthyCheckSM Centers: **\$25 or \$75 Copay** for basic or premium screening, deductible waived (for ages 7 and older)
NON-NETWORK:
 Annual physical exam, routine mammogram, Pap and PSA tests: **50% Coinsurance**
 Well-Child (through age 6): **50% Coinsurance**

Maternity

Not Covered

Optional Coverage (at additional cost)

Dental, Life

Prescription Drug Coverage

SmartSense

Retail Drugs (and Mail Order Drugs when available)

Standard Drug Coverage:

Tier 1 (Generic drugs): \$15 Copay
 \$7,500 annual Prescription Drug deductible per member applies before the following:
 • **Tier 2 (Formulary Brand name drugs): \$40 Copay**
 • **Tier 3 (Non-Formulary Brand name drugs): \$60 Copay**
 • **Specialty: 25% Coinsurance** up to a \$2,500 annual Prescription Drug out-of-pocket maximum (the most you'll have to pay), network only and in addition to \$7,500 annual deductible.
NON-NETWORK: Not Covered

Optional Drug Coverage (when available)

Upgrade Drug Coverage:

Tier 1 (Generic drugs): \$15 Copay
 \$500 annual Prescription Drug deductible per member applies before the following:
 • **Tier 2 (Formulary Brand name drugs): \$40 Copay**
 • **Tier 3 (Non-Formulary Brand name drugs): \$60 Copay**
 • **Specialty: 25% Coinsurance** up to a \$2,500 annual Prescription Drug out-of-pocket maximum (the most you'll have to pay), network only and in addition to \$500 annual deductible.
NON-NETWORK: Not Covered

Other Covered Benefits include but are not limited to:

Ambulance, Chiropractic Services, Home Health Care, Mental Health, Physical/Occupational Therapy, Urgent Care

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

NOTES:
 - Discounted rates apply for network covered services.
 - Network and non-network deductibles are separate and do not accumulate toward each other. Network and non-network out-of-pocket maximums are also separate and do not accumulate toward each other.
 - For non-network services, member is responsible for the coinsurance plus charges in excess of the allowable amount.
 - Copays/coinsurance to network and non-network providers apply to annual out-of-pocket maximum except where specifically noted in the policy.

Premier Is this the right plan for you?

Premier is a great choice for families or for individuals looking for robust benefits for both routine and unexpected medical care.

Premier Plan Highlights

Premier offers many benefits before the deductible and richer coverage as well for preventive care and prescription drugs. The lowest levels of coinsurance across all deductibles gives Premier added value over other plans we offer.

Features:

- Unlimited doctor office visits with predictable copays, before the deductible.
- A broad range of preventive benefits help focus on keeping you healthy.
- Annual routine eye exam.
- \$7 million per member in lifetime benefits.

You should know:

- Premier offers one of our highest levels of benefits, so the premiums are typically more than our other plans.
- Maternity benefits are not included with this plan.

Premier Preventive Care

Preventive care is an important component of Premier plan coverage. An annual physical exam and certain preventive screenings are covered, before your deductible, once you've been on the plan for six months. See the following Benefit Guide for more details.

You also have immediate access to a HealthyCheckSM Center for annual preventive screenings without first needing to meet your deductible. For more information about HealthyCheckSM, go to anthem.com/healthycheck.

Prescription Drug Coverage

The cost of prescription drugs can be overwhelming so Premier includes prescription drug coverage to help you manage those costs.

Premier prescription drug coverage includes the following tiers which represent a cost level within the generic and brand name prescription drug categories.

- **Tier 1:** These drugs have the lowest copay and include generic medications.
- **Tier 2:** These drugs have a higher copay than those in Tier 1 and include formulary brand name medications.
- **Tier 3:** These drugs have a higher copay than those in Tier 2 and include non-formulary brand name medications.
- **Specialty:** These are typically high-cost, scientifically engineered drugs and are paid at a coinsurance level instead of copay.

How to Customize your Premier Plan

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

Deductible: Premier plan deductibles range from \$1,000 to \$6,000. You can usually lower your premium by choosing a higher deductible. Simply choose the deductible and premium combination that works best for you.

Other Optional Coverage: You can add more protection for you and your family by purchasing optional dental or life insurance. See the following pages for details.

Benefits

Calendar Year Deductible

		Individual	Family	Network	Non-Network	Individual	Family	Network	Non-Network
Individual	NETWORK:	\$1,000	\$2,000	25%	25%	\$1,500	\$3,000	25%	25%
	NON-NETWORK:	\$1,000	\$2,000	25%	25%	\$1,500	\$3,000	25%	25%
Family	NETWORK:	\$2,000	\$4,000	25%	25%	\$3,000	\$6,000	25%	25%
	NON-NETWORK:	\$2,000	\$4,000	25%	25%	\$3,000	\$6,000	25%	25%

Calendar Year Out-of-Pocket Maximum

		Individual	Family	Network	Non-Network	Individual	Family	Network	Non-Network
Individual	NETWORK:	\$4,500	\$9,000	25%	25%	\$4,500	\$9,000	25%	25%
	NON-NETWORK:	\$7,500	\$15,000	25%	25%	\$7,500	\$15,000	25%	25%
Family	NETWORK:	\$9,000	\$18,000	25%	25%	\$9,000	\$18,000	25%	25%
	NON-NETWORK:	\$15,000	\$30,000	25%	25%	\$15,000	\$30,000	25%	25%

How family deductibles and family out-of-pocket maximums work

Once one family member reaches their individual deductible or out-of-pocket maximum, the remaining amount of the family deductible or out-of-pocket maximum needs to be met by one or more other family members. The family deductible or out-of-pocket maximum can be met by the family combined.

Plan Lifetime Maximum

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

Covered Services

Doctors' Office Visits

NETWORK: Office Visit **\$30 Copay** for primary care physician; **\$50 Copay** for specialist (deductible waived for both)
NON-NETWORK: **50% Coinsurance**

Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.)

NETWORK: **25% Coinsurance**
NON-NETWORK: **50% Coinsurance**

Inpatient Services (overnight hospital/facility stays)

NETWORK: **25% Coinsurance**
NON-NETWORK: **50% Coinsurance**

Outpatient Services (without overnight hospital/facility stays)

NETWORK: **25% Coinsurance**
NON-NETWORK: **50% Coinsurance**

Emergency Room Services

NETWORK: **25% Coinsurance**
NON-NETWORK: **25% Coinsurance**

Preventive Care Services

NETWORK: HealthyCheckSM Centers (deductible waived): **\$25 or \$75 Copay** for basic or premium screening (for ages 7 and older)
For members covered more than 6 months^{1,2} (deductible waived for the following):
 - Annual physical exam: **\$30 Copay**
 - Routine mammogram, Pap and PSA tests: **\$30 Copay**
 - Well-Child (through age 6): **\$30 Copay**
 Colorectal cancer screening: **25% Coinsurance (after deductible)**
NON-NETWORK: **50% Coinsurance**

Maternity

Not Covered

Optional Coverage (at additional cost)

Dental, Life

Prescription Drug Coverage

Retail Drugs (and Mail Order Drugs when available)

Premier
Tier 1 (Generic drugs): \$15 Copay
 \$500 annual Prescription Drug deductible per member applies before the following:
 • **Tier 2 (Formulary Brand name drugs): \$40 Copay**
 • **Tier 3 (Non-Formulary Brand name drugs): \$60 Copay**
 • **Specialty: 25% Coinsurance** up to a \$2,500 annual Prescription Drug out-of-pocket maximum (the most you'll have to pay), network only and in addition to \$500 annual deductible.
NON-NETWORK: Not Covered

Optional Drug Coverage (when available)

Not Applicable

Other Covered Benefits include but are not limited to:

Ambulance, Chiropractic Services, Home Health Care, Mental Health, Physical/Occupational Therapy, Urgent Care, Vision Exam

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¹For members covered less than 6 months, services are covered after the deductible.

²\$200 annual maximum benefit for preventive care lab work (excluding mammogram, Pap and PSA tests).

NOTES:

- Discounted rates apply for network covered services.
- Network and non-network deductibles are separate and do not accumulate toward each other. Network and non-network out-of-pocket maximums are also separate and do not accumulate toward each other.
- For non-network services, member is responsible for the coinsurance plus charges in excess of the allowable amount.
- Copays/coinsurance to network and non-network providers apply to annual out-of-pocket maximum except where specifically noted in the policy.

Affordable Dental Blue[®] PPO solutions designed to meet your dental needs

Dental Blue Basic offers:

- Low plan premiums
- Coverage for many diagnostic services and preventive care such as cleanings, exams and X-rays with no waiting period
- Coverage for certain basic services (fillings) with a six-month waiting period
- An annual maximum benefit of \$500

Dental Blue Enhanced offers:

- Coverage for many diagnostic services and preventive care such as cleanings, exams and X-rays with no waiting period
- Coverage for certain basic services (fillings) with a six-month waiting period
- Coverage for certain major services like root canals, periodontal procedures and crowns after a 12-month waiting period
- An annual maximum benefit of \$1,250
- Orthodontic coverage for children after a 12-month waiting period

Save money by using our dental network

As a Dental Blue member, you can see *any* dentist you want; however, you do have the potential for lower costs when you choose a dentist in the Dental Blue 100 network. This is because network dentists have agreed to accept our negotiated rates for services they provide to you. If you choose to go to a provider outside of the Dental Blue 100 network, you can be billed the difference between our network negotiated rates and what your chosen dentist wishes to charge. But, with more than 18,000 California dentists in our Dental Blue 100 network, it's likely your dentist is part of our network!

Plus, network dentists have agreed to pass along our negotiated rates to you during waiting periods, if you exceed your annual maximum benefit – and even for certain non-covered services such as veneers, dental implants and TMJ!

You will also have access to emergency dental care from our worldwide listing of credentialed dentists while traveling or working nearly anywhere in the world.

Prefer a Dental HMO?

If so, our Dental SelectHMO plan may be the right choice for you. For more information about the Dental SelectHMO plan – or our Dental Blue plans – ask your agent.

Amounts shown below are paid by the plan, after the deductible.

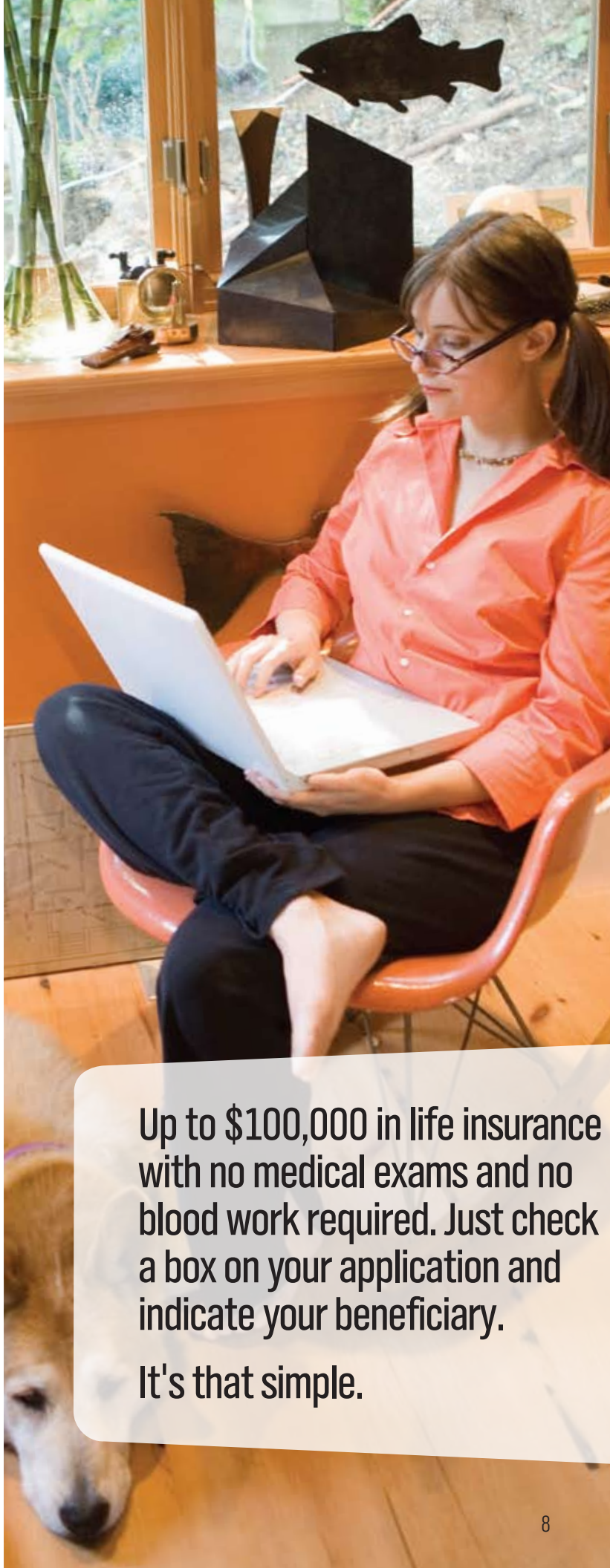
Dental Care Coverage	Dental Blue Basic		Dental Blue Enhanced	
	Network	Non-Network	Network	Non-Network
Annual Deductible	\$25 per member		\$50 per member; \$150 maximum per family	
Waived for Diagnostic & Preventive	Yes	No	Yes	No
Annual Maximum	\$500		\$1,250	
Diagnostic and Preventive	Network	Non-Network	Network	Non-Network
Cleanings, exams and X-rays	100%	80%	100%	80%
Basic Services	Network	Non-Network	Network	Non-Network
Fillings	80%	60%	80%	60%
Other Minor Restorative	Not covered			
Major Services	Network	Non-Network	Network	Non-Network
Oral Surgery	Not covered		50%	
Endodontics	50%; pulpotomies on primary teeth only		50%	
Periodontics	Not covered		50%	
Prosthodontics	50%; stainless steel crowns on primary teeth only		50%	
Orthodontics	Not covered		Children only: 50%; \$100 deductible; \$500 per year; \$1,000 lifetime maximum	
Waiting Periods	None for cleanings, exams and X-rays; 6 months for all other covered services		None for cleanings, exams and X-rays; 6 months for basic services; 12 months for major services/orthodontics	

Term Life Insurance

Losing a loved one is painful enough without having to worry about finances. Give your family extra support with term life insurance from Anthem Blue Cross Life and Health Insurance Company.

If you're accepted for coverage on one of our health care plans, you'll automatically be approved for our term life insurance. Plus, there are no medical exams or additional enrollment forms to worry about. It's that simple.

Term life monthly rates					
Age	\$15,000 Benefit	\$30,000 Benefit	\$50,000 Benefit	\$75,000 Benefit	\$100,000 Benefit
1-18	\$1.50	\$3.00	N/A	N/A	N/A
19-29	\$2.80	\$5.60	\$9.30	\$11.25	\$13.00
30-39	\$3.25	\$6.50	\$10.80	\$13.50	\$16.00
40-49	\$7.50	\$15.00	\$25.00	\$33.75	\$42.00
50-59	\$20.90	\$41.80	\$69.60	\$97.50	\$125.00
60-64	\$29.40	\$58.80	\$98.00	\$142.50	\$185.00



Up to \$100,000 in life insurance with no medical exams and no blood work required. Just check a box on your application and indicate your beneficiary. It's that simple.

Additional information

"No Obligation" review period

After you enroll in a plan offered by Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company, you will receive a Policy/EOC booklet that explains the exact terms and conditions of coverage, including the plan's exclusions and limitations. You will have 10 days to examine your plan's features. During that time, if you are not fully satisfied, you may decline by returning your Policy/EOC booklet along with a letter notifying us that you wish to discontinue coverage. Policy/EOC booklets are available for you to examine prior to enrolling. Ask your agent or Anthem Blue Cross.

Save time with automatic premium payment

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



Ready to choose a plan?

- After reviewing all the materials included with this brochure, contact your Anthem Blue Cross agent.
- Ask questions. If you aren't sure about how a plan works or have additional questions, your agent will help you.
- Fill out an application. The quickest and easiest way to complete an application is online and your agent can assist you. Or your agent can provide you with instructions for mailing or faxing your application.

If you have questions or want more details about your options, call your Anthem Blue Cross agent today!



Individual health coverage. Your plans. Your choices.

The Premier plan is available effective April 1, 2010.

Make sure you have all the facts.

This brochure is only one piece of your plan information. Please make sure you have all the facts about the benefits offered by the plan(s) described – including what's covered, and what isn't. For additional information about exclusions, limitations, and terms of this coverage, please see the enclosed Disclosure Document. This document should be included with your information kit, or if you have printed this from your computer, it should be at the end of this document. If you don't have this document, be sure to contact your Anthem Blue Cross agent.

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

Ready to enroll?

Call your Anthem Blue Cross agent today!

CoreGuardSM, ClearProtectionSM, Premier, SmartSense[®], Basic PPO, 3500 Deductible PPO, PPO 3500 HSA Compatible, Lumenos[®] HSA, RightPlan PPO 40, PPO Share, Select HMO, HMO Saver, Individual HMO*

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

To Enroll, You And Your Dependents Must Be:

- Age 64¾ or younger
- A permanent legal resident of California
- A U.S. resident for at least the last 3 months
- The applicant's spouse or domestic partner, age 64¾ or younger
- The applicant's children (under 19 years of age), or the children (under 19 years of age) of the applicant's enrolling spouse or qualified domestic partner
- The applicant's unmarried dependent children between the ages of 19 through 22 ("dependent" as defined by the Internal Revenue Service)
- The applicant's child (of any age) who is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition and is chiefly dependent upon the applicant for support and maintenance

Medical Underwriting Requirement

We believe that the cost of our plans should be consistent with your expected health care needs and risk factors. That's why Anthem offers various levels of coverage. To determine individual medical risk factors, all applications are subject to medical underwriting. Depending on the results of the underwriting review, a number of things may happen:

- You may be offered coverage at the standard premium charge
- You may be offered the plan you selected at a higher rate
- You may not qualify for the plan listed in this brochure
- You may be offered an alternate plan

If you have a significant medical condition and do not qualify for the plan you've chosen or if you have discontinued group coverage, please contact your Anthem representative for information regarding other Individual coverage options.

Incurred Medical Care Ratio

As required by law, we are advising you that Anthem Blue Cross' incurred medical care ratio for 2008 was 83.38 percent. This ratio was calculated after provider discounts were applied.

Exclusion And Look-Back Periods

For all PPO plans offered by Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company, there is a specific six-month **exclusion period** for coverage of any condition, disease or ailment for which medical advice or treatment was recommended or received within the **look-back period**. The look-back period is six months preceding the effective date of coverage for policies with three or more members and twelve months preceding the effective date of coverage for policies with one or two members.

If the number of enrolled members on your plan/policy increases from one or two to three or more, the look-back period will decrease to six (6) months. If the number of enrolled members on your plan/policy decreases from three or more to one or two, the look-back period will not change and will remain at six (6) months.

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

What Individual Health Care Plans Do Not Cover

The following overview will help you understand what your health care plan does not include before you enroll. For a comprehensive list of the plans' exclusions and limitations, you can request a copy of the Policy/Evidence of Coverage (EOC).

Medical Exclusions And Limitations

- Maternity or pregnancy care, unless the plan selected specifically includes maternity care (not applicable to HMO plans)
- Conditions covered by workers' compensation or similar law
- Experimental or investigative services
- Services provided by a local, state or federal government, unless you have to pay for them
- Durable Medical Equipment, except as specifically stated in the policy
- Services or supplies not specifically listed as covered under the Policy/EOC
- Services received before your effective date or after coverage ends
- Services you wouldn't have to pay for without insurance

Medical Exclusions And Limitations (continued)

- Services from relatives
- Any services received by Medicare benefits without payment of additional premium
- Services or supplies that are not medically necessary
- Routine physical exams, except for preventive care services (e.g., physical exams for insurance, employment, licenses or school are not covered), except as specifically stated in the Policy/EOC
- Any amounts in excess of the maximum amounts listed in the Policy/EOC
- Sex changes
- Cosmetic surgery
- Services primarily for weight reduction except medically necessary treatment of morbid obesity
- Dental care, dental implants or treatment to the teeth, except as specifically stated in the Policy/EOC
- Orthodontic services, braces, and other orthodontic appliances
- Hearing aids
- Infertility services
- Private duty nursing
- Eyeglasses or contact lenses, except as specifically stated in the Policy/EOC
- Vision care including certain eye surgeries to replace glasses, except as specifically stated in the Policy/EOC
- Specialty drugs from a pharmacy other than our specialty drug provider
- Certain orthopedic shoes or shoe inserts, except as specifically stated in the Policy/EOC
- Services or supplies related to a pre-existing condition
- Outdoor treatment programs
- Telephone or facsimile machine consultations
- Educational services except as specifically provided or arranged by Anthem
- Nutritional counseling, food or dietary supplements, except for formulas and special food products to prevent complications of phenylketonuria (PKU)
- Care or treatment furnished in a non-contracting hospital, except as specifically stated in the Policy/EOC
- Personal comfort items
- Custodial care
- Outpatient speech therapy, except as specifically stated in the Policy/EOC
- Outpatient drugs, medications or other substances dispensed or administered in any outpatient setting
- Certain genetic testing

- Services or supplies provided to any person not covered under the Agreement in connection with a surrogate pregnancy

ClearProtection also does not cover:

- Mental and nervous disorders and substance abuse except as specifically stated in the Policy/EOC. Except severe mental illnesses and serious emotional disturbances of a child
- Chiropractic care

In addition the **Select HMO, HMO Saver** and **Individual HMO** plans do not cover:

- Care not authorized by your Primary Medical Group or Independent Practice Association
- Amounts in excess of customary and reasonable charges for care rendered by a non-participating provider without a referral from your PMG or IPA
- Chiropractic services
- Immunizations for foreign travel
- Treatment for chronic alcoholism or other substance abuse except as specifically stated in the Evidence of Coverage
- Inpatient mental care, including acute alcoholism and drug addiction benefits, except detoxification
- Treatment of mental and nervous disorders, except as specifically stated in the Evidence of Coverage
- Rehabilitative care specifically stated in the Evidence of Coverage
- Reconstructive surgery, purchase or replacement of artificial limbs or prosthesis except as specifically stated in the Evidence of Coverage
- Medical, surgical and/or psychological treatment of a sexual dysfunction, except when a sexual dysfunction is a result of a physical abnormality, defect or disease
- Medical, surgical services, supplies or treatment to the joint of the jaw (temporomandibular joint), upper jaw (maxilla) or lower jaw (mandible), unless related to a tumor or accident occurring while covered
- Routine physical examinations or tests that do not directly treat an acute illness, injury or condition unless authorized by your Primary Care Physician, except in no event will any physical examination or test required by employment or government authority, or at the request of a third party, such as a school, camp or sports-affiliated organization, be covered unless Medically Necessary
- Care or treatment of a pregnancy, or any condition related to pregnancy (except treatment of complications of pregnancy or Cesarean-section deliveries) when conception has occurred before the effective date of the plan agreement. However, if you were covered under Creditable Coverage within 63 days of becoming pregnant, the time spent under Creditable Coverage will be used to satisfy, or partially satisfy, the six (6) month period

Dental Blue[®] PPO Limitations And Exclusions

Limitations

This is a partial list of plan limitations. Please see the Individual Dental Plan Contract for a complete list.

- Oral Evaluations: Limited to two per calendar year
- Routine Cleaning or Periodontal Cleaning: Limited to two treatments per calendar year
- Fluoride: Fluoride treatment limited to two per calendar year for children up to age 19
- X-rays: Limited to one set of full-mouth X-rays or its equivalent in a five-year period
- Periapical X-rays: Limited to four films per year
- Bitewing X-rays: Limited to one set of up to four films twice per calendar year
- Sealants: Limited to children under 16 years of age for permanent unrestored first and second molars
- Treatment is limited to one application per tooth per lifetime
- Space Maintainers: Limited to once per quadrant per lifetime for children up to age 16. Includes all adjustments within six months of placement
- Restorations: Limited to once per surface per tooth every 24 months
- Periodontal Scaling: Limited to once per quadrant every 24 months
- Periodontal Surgery: Limited to one time per quadrant in a 36-month period
- Root Canal Therapy: Limited to one treatment per tooth for initial treatment and one retreatment per tooth – for permanent teeth only
- Stainless Steel Crowns: Limited to baby teeth only. Once per tooth in any five years
- Crowns: Limited to once per tooth in any five years
- Removable, Partial and Complete Dentures: Limited to once in five years. Benefits are payable for either complete or immediate dentures, but not both
- General Anesthesia: Covered only when used in conjunction with covered oral surgical procedures

Exclusions

This is a partial listing of plan exclusions. Please see the Individual Dental Plan Contract for a complete list.

- Prescribed drugs, pre-medication or analgesia including charges for nitrous oxide or any similar local anesthetic when the charge is made separately
- Occlusal guards
- Bleaching of non-vital discolored teeth
- Crown buildups on the same tooth as an amalgam or composite restoration that was done within the same calendar year
- Procedures to alter, restore or maintain occlusion, change vertical dimension, and replace or stabilize tooth structure lost by attrition, abrasion, erosion or bruxism

- Harmful habit appliances
- Services related to diagnosis or treatment related to the temporomandibular joint (TMJ)
- Dental implants and all adjunctive services performed in conjunction with the placement or removal of implants including but not limited to surgery, cleanings, maintenance and prosthetics placed on implants
- Infection control procedures, if billed separately
- Precision attachments
- Prefabricated resin crown or stainless steel crown with resin window
- Pulpotomy on permanent teeth
- Replacement of a prosthodontic appliance (fixed or removable) more often than once in any five-year period, whether under this contract or under any prior dental coverage
- Root canal therapy on baby teeth
- Sealants on restored teeth (occlusal surface)
- Temporary/interim prosthodontia or appliances (temporary crowns, bridges, partials, dentures, etc.)
- Biopsies
- Services or supplies not specifically listed in the covered services section of the Individual Dental Plan Contract

Dental SelectHMO Limitations And Exclusions

This is a partial listing of plan limitations and exclusions. Please see the Contract for a complete list.

- Experimental or investigative care or therapy
- Any condition for which benefits of any nature are recovered or found to be recoverable, whether by adjudication, settlement or otherwise, under any workers' compensation or occupational disease law, even if you do not claim these benefits. If there is a dispute or substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers' compensation, Anthem Blue Cross Life and Health Insurance Company will provide the plan benefits for such conditions subject to its right of recovery and reimbursement under California Labor Code Section 4903
- Any services for which you are entitled to receive Medicare benefits, whether or not Medicare benefits are actually paid
- Any services provided by a local, state, county or federal government agency, including any foreign government, except when payment under the plan is expressly required by federal or state law
- Services or supplies for which no charge is made, or for which no charge would be made if you had no insurance coverage, or services for which you are not legally obligated to pay
- Services received before your effective date or during an inpatient stay that began before your effective date
- Services rendered before coverage begins or after coverage ends
- Prescribed drugs, pre-medication or analgesia (including nitrous oxide)

Dental SelectHMO Limitations And Exclusions (continued)

- No benefits are provided for hospital or associated physician charges for any dental treatment that cannot be performed in the dentist's office because of your general health, mental, emotional, behavioral or physical limitations
- Unless an exception is specifically authorized by Anthem Blue Cross in writing, dental services must be received from your participating dentist or participating specialty dentist
- A dental treatment plan, which in the opinion of the participating dentist and/or Anthem Blue Cross is not dentally necessary for dental health or will not produce beneficial results
- Conditions caused by the inadvertent release of nuclear energy when government funds are available for treatment of illness or injury arising from such release of nuclear energy
- Treatment of fractures or dislocations
- Any treatment to correct a dental condition that resulted from dental services performed by a non-participating dentist while coverage is in effect and any dental services started by a non-participating dentist will not be the responsibility of the participating dentist or Anthem Blue Cross for completion
- Histopathological exams and/or the removal of tumors, cysts, neoplasms and foreign bodies not covered under the medical plan
- Teeth with questionable, guarded or poor prognosis are not covered for endodontic treatment, periodontal surgery or crown and bridge. Plan will allow for observation or extraction and prosthetic replacement
- Services received after the benefit limit under this agreement is reached

- Orthodontic services must be received from a participating orthodontist. In the event of loss of coverage for any reason, and at the time of loss of coverage you are still receiving orthodontic treatment, you will be responsible for the remainder of the cost for that treatment
- Replacement of lost or stolen orthodontic appliances or repair of orthodontic appliances that were broken due to negligence
- Myofunctional therapy and related services
- Surgical procedures incidental to orthodontic treatment, including but not limited to extraction of teeth solely for orthodontic reasons, exposure of impacted teeth, correction of micrognathia or macrognathia, or repair of cleft palate
- Changes in treatment necessitated by an accident of any kind
- Treatment related to the joint of the jaw (temporomandibular joint, TMJ) and/or hormonal imbalance

This document provides a brief summary of provisions, exclusions and limitations. If there is any difference between this document and the Policy, the Policy will prevail.

Selecting health coverage is an important decision.

To assist you, we are also providing you with the Brochure and Enrollment Application. If you did not receive one or more of these materials, please contact your Anthem Blue Cross agent to request them.

The Policy/Evidence of Coverage booklets are also available for you to examine before enrolling. Ask your agent or Anthem Blue Cross.

*The following plans are offered by Anthem Blue Cross: PPO Share 3500/7500, Select HMO, HMO Saver, Individual HMO and Dental Blue PPO. The following plans are offered by Anthem Blue Cross Life and Health Insurance Company: ClearProtection, CoreGuard, SmartSense, Premier, Basic PPO, PPO Share 5000, RightPlan PPO 40, 3500 Deductible PPO, PPO 3500 (HSA-Compatible) and Lumenos HSA. Anthem Blue Cross is the trade name of Blue Cross of California. Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company are independent licensees of the Blue Cross Association. © ANTHEM and LUMENOS are registered trademarks of Anthem Insurance Companies, Inc. © Dental Blue, SmartSense and the Blue Cross name and symbol are registered marks of the Blue Cross Association.