

EmployeeElect



EmployeeElect Health Care Plans

Designed for businesses with 2-50 employees.
Customize your choices. Control your costs.

Helping your employees stay healthy all year long

Health care coverage.

You know what's in it for your employees. But do you know what's in it for you?

Health coverage works to your advantage. It's that simple.

You have employees working for you. Why not health coverage, too?

- More tax breaks
- Fewer sick days
- More reasons for valued employees to stay
- And lots more control over what you pay

These are just a few of the reasons why health coverage works to your advantage — especially when you work with Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company.

You can control every dollar...and choose what makes sense.

You need to do what makes sense for your company, so Anthem Blue Cross gives you lots of ways to control how much you'll spend. You choose which plans you want to offer and how much you want to contribute — and give your company priceless advantages. Why? Because we've customized plans and created cost-control options specifically for businesses just like yours.

Sit back and relax...and let our solutions work for you.

Be sure to rely on the expert advice of your Anthem Blue Cross agent so you can get started today!

EmployeeElect advantages at-a-glance:

- **A full choice** of PPO, HMO and HSA-compatible plans.
- **A sure thing** - If you're a qualifying California small business, you're guaranteed coverage...regardless of the health history of any employees. Also, you cannot be charged more than 10 percent over the standard rate — and you actually might pay up to 10 percent **under** the standard rate.
- **Offer just one plan, a combination of a few plans, or all plans** - designing your portfolio is up to you.
- **You control the cash flow** - simply choose the employer contribution option that works for you, and your employees will pay the rest through payroll deductions:
 - *Fixed Dollar* - you pay \$100 or more (in \$5 increments)
 - *Traditional* - you pay 50 percent or more
 - *Percentage & Plan* - you pay 50 percent or more, tied to a specific plan*
- **Guaranteed rates** and benefits for your first year of coverage.
- **Convenient online tool** for easy upkeep all year long.
- **Solutions that work** for you and your employees — based on our experience, strength and stability.

Rather not pick up the whole tab?

You don't have to pay the entire cost for health coverage. You choose the amount you pay and how much your employees will cover.

360° Health® — a valuable part of every plan, all year round.

Quite simply, 360° Health gives you a way to help your employees be as healthy as they can be. A comprehensive suite of programs and services that work together to help achieve optimal health outcomes, 360° Health offers access to:

- Online resources, including helpful decision-making tools
- Interactive health programs
- Discounts on health-related products

Your employees also will appreciate the personalized programs that help manage and coordinate care for over 40 chronic conditions. 360° Health can help your employees at all stages of their lives, and wherever they are along the health spectrum.

Note: For Lumenos® plans, 360° Health programs may vary.

Don't like putting up the "help wanted" sign?

As a professional risk manager, imagine your balance sheet after offering health coverage. You'll retain happy and healthy employees — and spend your valuable time growing, instead of interviewing.



Dental, life and workers' compensation. Complete your benefits package — and complete your savings!

Anthem Blue Cross offers a complete benefits package for your employees...and spectacular savings opportunities for you.

- **1% medical savings** - When you purchase \$25,000 or more in life along with medical, you'll qualify for 1 percent savings* on your medical premium — making life insurance more affordable than ever.
- **6% life savings plus 6% dental savings** - When you purchase both \$25,000 or more in life and any of our insured dental plans at the same time, receive 6 percent savings on your life premium and 6 percent savings on your dental premium. That's in addition to the 1 percent savings on your medical premium!

*.90 is the best Risk Adjustment Factor available

**Workers' compensation...you need it; we've got it...
with a discount built right in!**

That's right — when you integrate workers' compensation coverage from Employers Compensation Insurance Company with any of our medical plans, you get an automatic 10 percent discount off the workers' compensation portion of your bill.

You may qualify for additional savings on your medical premium! Ask your Anthem Blue Cross agent about these incredible savings opportunities!



Looking for some tax breaks?

Offering health coverage to your employees can be 100 percent tax deductible on both your state and federal income taxes. And you may get to deduct other coverage-related costs, such as contributions made to your employees' Health Savings Accounts (HSAs). Consult your tax professional for more information.

EmployerAccess

An easy way to manage your company's health benefits all year long.

With our online benefit administration tool, EmployerAccess, you can quickly and conveniently perform simple benefit functions in real time.

Here's what you can do:

- View your employees' coverage
- Enroll employees and add dependents
- Change or cancel coverage for employees and dependents
- Request ID cards
- View open invoices
- Pay bills online
- Schedule payments
- Manage your bank account used for payments
- View 12 months of past invoices

Gain more control and enjoy the benefits of managing your medical, dental, vision and life coverage in one seamless online experience. Visit [anthem.com/ca](https://www.anthem.com/ca) or ask your Anthem Blue Cross agent for more details.

Want to save even more?

Ask your Anthem Blue Cross agent about a Premium Only Plan (P.O.P.)

A P.O.P. allows you to use pre-tax salary dollars to pay your employees' share of benefit premiums. And employees reduce their taxable income, which lowers their taxes and increases their take-home pay. You cut your payroll taxes by decreasing your total taxable payroll. Everybody wins — and saves.

- With Ceridian Benefits Services, the cost of a Premium Only Plan is only \$125 per year.
- Your first year could be free if you have 10 or more medical and life enrolling employees.

Talk to your tax advisor for all the advantages.

You're already saving time and money, and you haven't even started! Interested?

Benefits listed are per-member costs, subject to deductible and copayments, unless otherwise stated.

What are your priorities?

The EmployeeElect portfolio gives you ultimate flexibility and a wide range of plans to choose from, including PPOs, HSAs (consumer-driven health plans) and HMOs. To help you better understand your options, we have separated our plans into seven categories:

- Affordable Protection
- Solution
- Dollars & Sense
- First Things First
- Ideal Balance
- Simple & Consistent
- Superior Designs

First

Use the grids on the following pages to start building your company's medical benefits package. Consider your priorities and note which plans match those needs. Compare key benefits and relative prices.

Next

Go to the page number shown in the first column for more detailed plan information. Before making your final selections, be sure to review the exclusions and limitations at the end of this brochure and the *Summary of Features* brochures for your chosen plans.

	PLANS	Annual Deductible
Affordable Protection Our most affordable PPOs provide solid protection at budget-friendly prices. <i>See pages 10 and 11</i>	Basic PPO**	\$1,250
	Saver PPO**	\$500 See pages 10-11 for details
	PPO \$45 Copay GenRx**	\$750
	PPO \$35 Copay GenRx**	\$500
Solution <i>See pages 12 and 13</i>	Solution 2500 PPO**	\$2,500
	Solution 3500 PPO**	\$3,500
	Solution 5000 PPO**	\$5,000
Dollars & Sense These HSA-compatible PPO plans offer comprehensive health coverage and a savvy financial strategy all in one. <i>See pages 14 and 15</i>	PPO 3500 (HSA-compatible)**	\$3,500 (medical/pharmacy combined)
	PPO 2400 (HSA-compatible)**	\$2,400 (medical/pharmacy combined)
	High Deductible EPO*	\$2,000 (medical/pharmacy combined)
	Lumenos HSA 3000** (HSA-compatible)	\$3,000 (medical/pharmacy combined)
	Lumenos HSA 2000** (HSA-compatible)	\$2,000 (medical/pharmacy combined)
	Lumenos HSA 1500** (HSA-compatible)	\$1,500 (medical/pharmacy combined)

KEY BENEFITS

Member in-network costs shown here — go to pages shown in the first column for per-family costs and more complete benefit details.

Annual Out-of-Pocket Maximum	Office Visits	Prescription Drugs	Inpatient Hospital Charges	RELATIVE PRICE \$ —————> \$\$\$
Deductible + \$2,000	Not covered	\$10 generic/\$25 brand-name See pages 10-11 for limits.	20% after deductible	
\$2,000	Limited coverage See pages 8-9 for details.	\$10 generic/\$25 brand-name See pages 10-11 for limits.	20% after deductible	
\$4,500	\$45/first 12; then 45%	Generic only: \$15 (Anthem Blue Cross-negotiated savings on in-network brand-name drugs)	45% after deductible	
\$4,000	\$35/first 12; then 45%	Generic only: \$15 (Anthem Blue Cross-negotiated savings on in-network brand-name drugs)	35% after deductible	
\$5,000	\$25 copay for unlimited visits	\$15 generic/\$25 - \$50 brand-name, after \$250 brand-name deductible	25% after deductible	
\$5,000	\$35 copay for unlimited visits	\$15 generic/\$35 - \$50 brand-name, after \$250 brand-name deductible	35% after deductible	
\$7,500	\$40 copay for unlimited visits	\$15 generic/\$35 - \$50 brand-name, after \$250 brand-name deductible	40% after deductible	
\$4,000 (medical/pharmacy combined)	\$35 after deductible	\$10 generic/\$25 brand-name after annual deductible	0% after deductible	
\$3,600 (medical/pharmacy combined)	\$35 after deductible	\$10 generic/\$25 brand-name after annual deductible	20% after deductible	
\$3,100 (medical/pharmacy combined)	20% after deductible	\$10 generic/\$25 brand-name after annual deductible	20% after deductible	
\$3,000 (medical/pharmacy combined)	0% after deductible Deductible waived for nationally recommended preventive care services.	0% after annual deductible	0% after deductible	
\$2,000 (medical/pharmacy combined)	0% after deductible Deductible waived for nationally recommended preventive care services.	0% after annual deductible	0% after deductible	
\$1,500 (medical/pharmacy combined)	0% after deductible Deductible waived for nationally recommended preventive care services.	0% after annual deductible	0% after deductible	

Relative price illustrations are based on the average Standard Employer Risk Rates for each plan. Please request a quotation for actual rates, which will vary according to geographic area and the group's risk profile.

Important: These charts are designed to help begin the selection process; they do not provide adequate information to make a final decision. Benefits listed are per-member in-network costs, subject to deductible and copayments unless otherwise stated, for initial comparison purposes only. For more complete highlights, including per-family costs, go to the pages shown in the first column. Do not submit an application until you review each plan's Summary of Features brochure and the Sales and Enrollment guide. This is a high level overview only, refer to the **Combined Evidence of Coverage and Disclosure Form or Certificate** for a comprehensive description of coverage, benefits, exclusions and limitations.

*Offered by Anthem Blue Cross **Offered by Anthem Blue Cross Life and Health Insurance Company

Solutions growing right along with you...

At Anthem Blue Cross, we are committed to helping your business get covered and stay covered.

We've been serving California's small businesses for nearly seven decades, so we understand some of the unique challenges you face. We know that you've worked hard to get where you are – and that you have important goals for the future.

We have the strength, stability and experience to create solutions that work for you...now and as your business needs change. And, since we're constantly seeking new ways to support small businesses, our solutions will be growing right along with you.

Benefits listed are per-member costs, subject to deductible and copayments, unless otherwise stated.

First Things First

These plans give you first-dollar coverage for many of the services you need most.

See pages 16 and 17

Ideal Balance

Looking for an ideal mid-range cost and comprehensive benefit balance? Take a look.

See pages 18 and 19

Simple & Consistent

HMO plans are great if you want to simplify decision-making and pay predictable costs.

See pages 20 and 21

Superior Designs

These top-of-the-line PPO plans have rich benefits and low deductibles.

See pages 22 and 23

PLANS

Annual Deductible

Power HealthFund 500**	First, plan pays \$500; then member pays \$1,000 deductible
Power HealthFund 750**	First, plan pays \$750; then member pays \$500 deductible
Lumenos HIA Plus 3000**	Health Incentive Plan allocation \$1,000 single member (applies to deductible) Annual deductible \$3,000 single member (medical/pharmacy combined) ¹
PPO \$40 Copay*	\$500
PPO \$30 Copay*	\$500
Advantage PPO \$25 Copay**	\$250
Power \$35 SelectHMO*	\$1,000
Power SelectHMO*	\$500
Saver \$30 HMO*	\$2,500
Saver HMO*	\$1,500
Classic \$30 HMO*	None
Classic HMO*	None
HMO \$25 100%	None
HMO 100%*	None
Premier PPO \$20 Copay*	\$250
Premier PPO \$10 Copay*	\$250

¹First dollar coverage prorated the first year when effective date is not January 1.

KEY BENEFITS

Member in-network costs shown here – go to pages shown in the first column for per-family costs and more complete benefit details.

Annual Out-of-Pocket Maximum	Office Visits (not subject to deductible)	Prescription Drugs	Inpatient Hospital Charges	RELATIVE PRICE \$ —————> \$\$\$
\$5,000	\$40 after first dollar coverage and deductible	\$10 generic/\$35 brand-name after \$350 brand-name deductible	40% after first dollar coverage and deductible	
\$5,000	\$35 after first dollar coverage and deductible	\$10 generic/\$30 brand-name after \$250 brand-name deductible	25% after first dollar coverage and deductible	
\$3,000 (medical/ pharmacy combined)	0% after deductible Deductible waived for nationally recommended preventive care services.	0% after annual deductible	0% after deductible	
\$4,500	\$40/first 12; then 45%	\$15 generic/\$25 brand-name after \$150 brand-name deductible	40% after deductible	
\$4,000	\$30/first 12; then 45%	\$15 generic/\$25 brand-name after \$150 brand-name deductible	30% after deductible	
\$3,600	\$25/first 12; then 45% up to \$900; then 10% up to \$3,600	\$15 generic/\$25 brand-name	30% up to \$900, then 10% up to \$3,600 after deductible	
\$3,000	\$35/primary care physician; \$50/specialist and referral	\$15 generic/\$25 brand-name after \$150 brand-name deductible	20% after deductible	
\$2,250	\$25/primary care physician; \$35/specialist and referral	\$15 generic/\$25 brand-name after \$150 brand-name deductible	10% after deductible	
\$3,000	\$30/primary care physician; \$40/specialist and referral	\$10 generic/\$25 brand-name after \$150 brand-name deductible	No charge after deductible	
\$2,250	\$20	\$10 generic/\$25 brand-name after \$150 brand-name deductible	No charge after deductible	
\$2,500	\$30/primary care physician; \$40/specialist and referral	\$10 generic/\$25 brand-name after \$150 brand-name deductible	\$500 copay per admission	
\$1,750	\$20	\$10 generic/\$25 brand-name after \$150 brand-name deductible	\$250 copay per admission	
\$1,750	\$25	\$10 generic/\$20 brand-name after \$150 brand-name deductible	No charge	
\$1,750	\$10	\$10 generic/\$20 brand-name after \$150 brand-name deductible	No charge	
\$3,000	\$20/first 12; then 40%	\$15 generic/\$25 brand-name	20% after deductible	
\$2,500	\$10/first 12; then 30%	\$10 generic/\$20 brand-name	10% after deductible	

Relative price illustrations are based on the average Standard Employer Risk Rates for each plan. Please request a quotation for actual rates, which will vary according to geographic area and the group's risk profile.

Important: These charts are designed to help begin the selection process; they do not provide adequate information to make a final decision. Benefits listed are per-member in-network costs, subject to deductible and copayments unless otherwise stated, for initial comparison purposes only. For more complete highlights, including per-family costs, go to the pages shown in the first column. Do not submit an application until you review each plan's *Summary of Features* brochure and the *Sales and Enrollment Guide*. This is a high level overview only, refer to the Combined Evidence of Coverage and Disclosure Form or Certificate for a comprehensive description of coverage, benefits, special circumstances and limitations.

Our PPO plans feature:

- Access to over 53,000 California PPO network doctors and specialists and nearly 400 hospitals - so chances are your employees' doctors are in our network.
- Money stays in your employees' pockets - because we've negotiated lower fees with the doctors and hospitals in our network, your employees save.
- Out-of-state coverage - our health coverage goes with your employees when they travel.

Affordable Protection

Basic PPO - Our most affordable PPO plan offers peace of mind with valuable hospital-only coverage.

Saver PPO - This affordable PPO plan provides hospital-only coverage as well as limited benefits for professional services.

PPO \$45/\$35 Copay GenRx - Comprehensive PPO plans with a generic-only drug benefit to keep premiums affordable.

¹ Basic PPO and Saver PPO are basic hospital-only and limited professional benefits plans. Some covered services are limited.

² The \$500 deductible applies to hospital inpatient facility and professional services, hospital outpatient surgery, medical emergency, radiation therapy, hemodialysis treatment, infusion therapy, acupuncture/acupressure, professional services related to covered hospital outpatient surgical services, ambulance, skilled nursing facility stays, home health care, and covered mental health services (see note 3 about the separate \$5,000 deductible).

³ The \$5,000 deductible (separate from the \$500 deductible) begins to accumulate after annual initial office visits (2 per adult/4 per child) are used, and after initial maximum diagnostic lab and X-rays benefits are paid by the plan (see Certificate for details); once a member meets the \$5,000 deductible, then office visits, diagnostic lab and X-rays charges and additional eligible covered expenses are covered at 100% of eligible charges. Once two members of a family meet the \$5,000 deductible, the entire family is covered at 100% of eligible charges.

⁴ Expenses that contribute to the annual out-of-pocket maximum vary from plan to plan and have restrictions and limitations. Refer to each plan's Certificate for full details.

⁵ If a member selects a brand-name drug when a generic-equivalent drug is available, even if the physician writes a "dispense as written" or "do not substitute" prescription, the member will be responsible for the generic copay plus the difference in cost between the brand-name drug and the generic-equivalent drug.

*Must be done at a HealthyCheckSM designated facility

Basic PPO¹

Benefits listed are per-member costs, subject to deductible and copayments unless otherwise stated.

Annual Deductible		\$1,250 per member Two-member maximum
Annual Out-of-Pocket Maximum⁴	In-Network	Annual deductible plus \$2,000 per member, two-member maximum In-network and out-of-network combined
	Out-of-Network	
Office Visits	In-Network	Not covered
	Out-of-Network	
Professional Services Includes maternity, diagnostic lab and X-rays	In-Network	Limited professional services 20% of negotiated fee
	Out-of-Network	Limited professional services 50% of negotiated fee plus 100% of excess charges
Hospital Inpatient and outpatient	Participating Hospitals	20% of negotiated fee (limited outpatient services)
Emergency Care		
Prescription Drugs	In-Network	\$10 generic, \$25 brand-name; 30% of negotiated fee for self-administered injectable drugs, except insulin; maximum \$500 annual Anthem Blue Cross payment with continued access to Anthem Blue Cross negotiated pharmacy prices after maximum is reached ⁵
Not subject to annual medical deductible; amounts shown are copays for each 30-day supply; up to a 60-day supply is available through mail order.		
Preventive Care	In-Network	20% of negotiated fee after annual deductible
Includes well-baby immunizations; ages 7-adult screening tests include an annual Pap test, breast exam and mammogram for women and a prostate-specific antigen test for men.		
HealthyCheckSM* Annual Health Screening	In-Network	
Annual Physical Exam		

Saver PPO ¹	PPO \$45 Copay GenRx	PPO \$35 Copay GenRx
Covered hospital benefits and initial professional services ² : \$500 per member, two-member maximum; deductible applies to annual out-of-pocket maximum. Subsequent professional services with continued access to Anthem Blue Cross in-network savings: Member pays 100% of negotiated fee up to \$5,000 per member, two-member maximum. ³	\$750 per member, two-member maximum Waived for office visits, HealthyCheck screening and prescription drug copays; applies to out-of-pocket maximum	\$500 per member, two-member maximum Waived for office visits, HealthyCheck screening and prescription drug copays; applies to out-of-pocket maximum
Covered hospital benefits and initial professional services ² : \$2,000 per member, two-member maximum; includes annual deductible (in-and out-of-network combined). Subsequent professional services with continued access to Anthem Blue Cross in-network savings: \$5,000 per member. ³	\$4,500 per member, two-member maximum; includes annual deductible	\$4,000 per member, two-member maximum; includes annual deductible
	Anthem Blue Cross payment of \$10,000 per member's covered expenses	Anthem Blue Cross payment of \$10,000 per member's covered expenses
Initial two visits per adult /four visits per child (in-network and out-of-network combined): \$20 copay, the deductible is waived. Additional visits: member pays 100% of negotiated fee with continued access to Anthem Blue Cross savings. ³	First 12 office visits per member: \$45 copay Additional visits: 45% of negotiated fee; not subject to deductible	First 12 office visits per member: \$35 copay Additional visits: 45% of negotiated fee; not subject to deductible
Initial two visits per adult /four visits per child (in-network and out-of-network combined): 50% of negotiated fee plus 100% of excess charges, the deductible is waived. Additional visits: 100% of negotiated fee plus all excess charges. ³	50% of negotiated fee plus 100% of excess charges	50% of negotiated fee plus 100% of excess charges
Covered services, including maternity: 20% of negotiated fee. Diagnostic lab and X-rays: 20% of negotiated fee (up to a maximum \$500 Anthem Blue Cross payment in-network and out-of-network combined); then member pays 100% of negotiated fee with continued access to Anthem Blue Cross savings. ³	45% of negotiated fee	35% of negotiated fee
Covered services, including maternity: 50% of negotiated fee, plus 100% of excess charges. Diagnostic lab and X-rays: 50% of negotiated fee plus 100% of excess charges (up to a maximum \$500 Anthem Blue Cross payment in-network and out-of-network combined); then member pays 100% of negotiated fee plus all excess charges. ³	50% of negotiated fee plus 100% of excess charges	50% of negotiated fee plus 100% of excess charges
20% of negotiated fee (limited outpatient services)	45% of negotiated fee	35% of negotiated fee
\$100 emergency room copayment for each visit (waived if admitted)		
\$10 generic, \$25 brand-name; 30% of negotiated fee for self-administered injectable drugs, except insulin; maximum \$500 annual Anthem Blue Cross payment with continued access to Anthem Blue Cross negotiated pharmacy prices after maximum is reached. ³	\$15 generic; 30% of negotiated fee for generic self-administered injectable drugs, except insulin (plan covers generic drugs only)	\$15 generic; 30% of negotiated fee for generic self-administered injectable drugs, except insulin (plan covers generic drugs only).
20% of negotiated fee, not subject to annual deductible	\$45 office visit copay (not subject to deductible) plus 45% of negotiated fee for all other covered services (after annual deductible)	\$35 office visit copay (not subject to deductible) plus 35% of negotiated fee for all other covered services (after annual deductible)
\$25 or \$75 copay health screening options, not subject to annual deductible		
Not covered		

Please note: In-network providers accept Anthem Blue Cross negotiated fee rates as payment in full for covered services. Benefits listed are based on the negotiated fee rate for in-network providers (out-of-network providers can charge more than the negotiated fee rate); benefits listed for out-of-network providers are based on customary and reasonable charges in cases of medical emergencies; when members use an out-of-network provider, they must pay the applicable copayment or coinsurance, plus any charges that exceed that allowable amount.

The Solution to your employees' needs

We've developed an ideal solution for employees who need to:

- See a doctor a few times a year, including for physical exams
- Save on prescriptions
- Have enough coverage for any unexpected hospital stays

What do we call this solution? High-deductible Solution PPO health plans.

Smart Solution

Solution PPO health plans are different than most other health plans because they focus on providing the coverage your employees want, need and will use the most, including:

- Predictable copays for doctor visits and prescriptions. In- and out-of-network doctor visits are unlimited.
- Preventive care benefits to keep your employees at peak performance.
- “Just in case” coverage for hospitalizations and other major medical expenses. It probably won't happen, but if unexpected illness or injury comes up, your employees will know that their plan's out-of-pocket max is the most they'll have to pay.

This means you can actually pay less and still get the comprehensive coverage your employees will use the most.

Maximum Lifetime Benefits	
Your Choices	
Annual Medical Deductible	\$2,500 per member. Two-member maximum, in-network and out-of-network combined
Annual Out-of-Pocket Maximum¹ Includes deductible unless noted	\$5,000 per member. Two-member maximum
Office Visits	\$25 copay. (Not subject to annual deductible)
Other Professional Services Including maternity, diagnostic lab and X-rays	25% after annual deductible
Hospital Inpatient	25% after deductible
Prescription Drugs Amounts shown are for a 30-day retail supply; mail order service is available	\$15 generic \$25 formulary brand ² \$50 non-formulary brand ² \$250 brand-name prescription drug deductible per member
Preventive Care	\$25 office visit copay (not subject to annual deductible) plus 25% after annual deductible for all other covered services beyond that related office visit
HealthyCheckSM Two levels of annual health screenings, including lab work and immunizations; must be done at a HealthyCheck Center	Not applicable
Annual Physical Exam (age 7-adult)³	Not subject to annual deductible \$25 copay for office visit plus 25% for all other covered services beyond that related office visit

¹ Expenses that contribute to the annual out-of-pocket maximum vary from plan to plan and have restrictions and limitations. Refer to each plan's Certificate for full details.

² If a member selects a brand-name drug when a generic equivalent drug is available, even if the physician writes a “dispense as written” or “do not substitute” prescription, the member will be responsible for the generic copay plus the difference in cost between the brand-name drug and the generic equivalent drug. The amount paid does not apply to the member's brand-name deductible.

³ Maximum annual Anthem Blue Cross payment is \$500 for members covered more than six months and \$250 for members covered six months or less.

Solution 3500 PPO

NEW!

Solution 5000 PPO

NEW!

\$5,000,000 in lifetime benefits per member

Modest premium plans with high deductibles, providing predictable office visit copayment, preventive care and physical exams covered prior to the deductible

	\$3,500 per member. Two-member maximum, in-network and out-of-network combined	\$5,000 per member. Two-member maximum, in-network and out-of-network combined
	\$5,000 per member. Two-member maximum	\$7,500 per member. Two-member maximum
	\$35 copay. (Not subject to annual deductible)	\$40 copay. (Not subject to annual deductible)
	35% after annual deductible	40% after annual deductible
	35% after deductible	40% after deductible
	\$15 generic \$35 formulary brand ² \$50 non-formulary brand ² \$250 brand-name prescription drug deductible per member	\$15 generic \$35 formulary brand ² \$50 non-formulary brand ² \$250 brand-name prescription drug deductible per member
	\$35 office visit copay (not subject to annual deductible) plus 35% after annual deductible for all other covered services beyond that related office visit	\$40 office visit copay (not subject to annual deductible) plus 40% after annual deductible for all other covered services beyond that related office visit
	Not applicable	Not applicable
	Not subject to annual deductible \$35 copay for office visit plus 35% for all other covered services beyond that related office visit	Not subject to annual deductible \$40 copay for office visit plus 40% for all other covered services beyond that related office visit

Please note: In-network providers accept Anthem Blue Cross negotiated fee rates as payment in full for covered services. Benefits listed are based on the negotiated fee rate for in-network providers (out-of-network providers can charge more than the negotiated fee rate); benefits listed for out-of-network providers are based on customary and reasonable charges in cases of medical emergencies; when members use an out-of-network provider, they must pay the applicable copayment or coinsurance, plus any charges that exceed that allowable amount.

You may have heard about HSAs...

A Health Savings Account (HSA) is separate from the health plan and is a convenient, optional way for you to pay for health care expenses on a tax-favored basis. You may use an HSA in conjunction with a qualifying high-deductible health plan, such as those listed here. To make sure you're getting every advantage of an HSA, we recommend talking with a tax advisor.

Dollars & Sense

PPO 2400/3500 (HSA-compatible) - These state-of-the-art solutions work hand-in-hand with a health savings account...giving you a health plan and financial strategy all in one. Along with comprehensive high-deductible PPO coverage, you have the option to utilize the tax advantages of an HSA.

Lumenos HSA 1500/2000/3000 - These HSA-compatible plans feature 100 percent preventive care coverage even before the annual deductible is met. Enjoy the benefits of comprehensive PPO coverage and – if you choose to open an HSA – you'll enjoy tax advantages, too! If you're interested in an HSA with our partner, Bank of New York Mellon, you can sign up for a Lumenos HSA plan and an HSA at the same time.

High-Deductible EPO - This Exclusive Provider Organization plan offers the opportunity to enjoy in-network-only PPO benefits as well as the tax advantages that come with teaming this plan with a HSA. Please note that this plan offers coverage for services in our Exclusive Provider Organization network only.

Maximum Lifetime Benefits	
Your Choices	This state-of-the-art solution works hand-in-employees the benefits of a health plan and
Annual Medical Deductible¹	\$3,500 per single member \$7,000 family aggregate Medical/pharmacy combined
Annual Out-of-Pocket Maximum^{1,2} Includes deductible unless noted	\$4,000 per single member \$7,500 family aggregate Medical/pharmacy combined
Office Visits	\$35 copay after deductible
Professional Services Including maternity, diagnostic lab and X-rays	0% after deductible
Hospital Inpatient	0% after deductible
Prescription Drugs Amounts shown are for a 30-day retail supply; mail-order services available.	\$10 generic \$25 brand-name ³ after deductible
Preventive Care	\$35 office visit copay (not subject to deductible) plan pays 100% of negotiated fee for all other covered services after deductible
HealthyCheckSM Two levels of annual health screenings, including lab work and immunizations; must be done at a HealthyCheck Center.	\$25 or \$75 copay options (Not subject to deductible)
Annual Physical Exam	OR \$35 office visit copay; plus any negotiated fee amount in excess of the Anthem Blue Cross payment ⁴ (Not subject to deductible)

¹ Per-family amount is aggregate, i.e., once one or more family members' eligible covered expenses (combined) meet this amount, the requirement is satisfied for all covered family members.

² Annual Out-of-Pocket Maximum: Expenses that contribute to the annual out-of-pocket maximum vary from plan to plan and have restrictions and limitations. Refer to each plan's *Combined Evidence of Coverage and Disclosure Form* or *Certificate* for full details.

³ If a member selects a brand-name drug when a generic equivalent drug is available, even if the physician writes a "dispense as written" or "do not substitute" prescription, the member will be responsible for the generic copay plus the difference in cost between the brand-name drug and the generic equivalent drug; the amount does not apply to the member's brand-name deductible.

⁴ Maximum annual benefit is \$200 for members covered more than six months and \$100 for members covered six months or less.

^{*}Must be done at a HealthyCheckSM designated facility.

PPO 2400 (HSA-Compatible)	Lumenos HSA 3000 (HSA-Compatible)	Lumenos HSA 2000 (HSA-Compatible)	NEW!	Lumenos HSA 1500 (HSA-Compatible)	High Deductible EPO
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\$5,000,000 in lifetime benefits per member

hand with an HSA giving your financial strategy all in one.	These consumer-driven health plans offer:				As an EPO (Exclusive Provider Organization), benefits are available in-network only. This plan also allows eligible employees to take advantage of tax benefits when they open a separate HSA.
	<ul style="list-style-type: none"> 100% coverage for preventive care in-network only before the annual deductible is met. Compatibility with a tax-advantaged HSA that helps pay for medical care and prescriptions. An out-of-pocket "bridge" to traditional health coverage. Comprehensive PPO coverage. 				
\$2,400 per single member \$4,800 family aggregate Medical/pharmacy combined	\$3,000 per single member \$6,000 family aggregate Medical/pharmacy combined	\$2,000 per single member \$4,000 family aggregate Medical/pharmacy combined	\$1,500 per single member \$3,000 family aggregate Medical/pharmacy combined	\$2,000 per single member \$4,000 family aggregate Medical/pharmacy combined	
\$3,600 per single member \$5,500 family aggregate Medical/pharmacy combined	\$3,000 per single member \$6,000 family aggregate Medical/pharmacy combined	\$2,000 per single member \$4,000 family aggregate Medical/pharmacy combined	\$1,500 per single member \$3,000 family aggregate Medical/pharmacy combined	\$3,100 per single member \$5,700 family aggregate Medical/pharmacy combined	
	0% after deductible Preventive care, including nationally recommended preventive care services, at 0% (not subject to deductible)			20% after deductible	
20% after deductible	0% after deductible			20% after deductible	
20% after deductible	0% after deductible			20% after deductible	
	0% after deductible			\$10 generic \$25 brand-name ³ after deductible	
\$35 office visit copay (not subject to deductible) plus 20% for all other covered services after deductible	0% Includes nationally recommended preventive care services. (Not subject to deductible)			20% after deductible	
\$25 or \$75 copay options (Not subject to deductible)	Not covered			\$25 or \$75 copay options (Not subject to deductible)	
OR					
\$35 office visit copay; 20% for all other covered services plus any negotiated fee amount in excess of the Anthem Blue Cross payment ⁴ (Not subject to deductible)	Covered under preventive care benefits			Not covered	

Please note: In-network providers accept Anthem Blue Cross Life and Health negotiated fee rates as payment in full for covered services. Benefits listed are based on negotiated fee rate for in-network providers (out-of-network providers can charge more than the negotiated fee rate); benefits listed for out-of-network providers are based on customary and reasonable charges in cases of medical emergencies; when members use an out-of-network provider, they must pay the applicable copayment or coinsurance, plus any charges that exceed the allowable amount.

Benefits listed are per-member costs, subject to deductible and copayments unless otherwise stated.

Our Power HealthFund Plans offer first-dollar coverage for whatever eligible benefits are needed before the deductible is met. Our Lumenos® Health Incentive Account (HIA) Plus plan actually adds credits to the health account when an employee participates in one or more of the plan's rewards programs (giving them even more money to pay for medical care expenses and prescriptions). These plans also focus on helping your employees maintain and improve their health...making “an ounce of prevention” more meaningful – and more attainable – than ever!

First Things First

Power HealthFund 750/500 plans - Looking for first-dollar coverage? These plans supply you with first-dollar funds that you can use for any covered services (except prescription drug benefits) before meeting your annual medical deductible. And, if you enroll prior to the last quarter of the year, any unused first-dollar funds roll over to the next year.* Another great feature is that the first-dollar coverage is aggregated, which means just one family member – or a combination of family members – can use it. So power up your health with the services you need now!

*Up to two times the first-dollar coverage amount.

Lumenos® HIA Plus - This unique plan allows you to use a health incentive account funded with contributions from your health plan** for covered services – including prescription drugs – before meeting your annual medical deductible. You also have 100% coverage for recommended preventive care. And all unused health account funds keep rolling over from year to year...for as long as you have the plan.

** Health account allocation is prorated the first year, based on any effective date other than January 1. Ask your Anthem Blue Cross agent for details based on your date of enrollment.

Health Incentive Allocation or First-Dollar Coverage¹

For immediate use to automatically pay for covered services

In-network and out-of-network combined

Annual Deductible¹

Applies toward the annual out-of-pocket maximum

Annual Out-of-Pocket Maximum^{1,2}

Includes annual deductible and coinsurance

In-Network

Out-of-Network

Office Visits

In-Network

Out-of-Network

Professional Services

Includes maternity, diagnostic lab and x-rays

In-Network

Out-of-Network

Hospital - Inpatient and outpatient

Participating Hospitals

Prescription Drugs

Amounts shown are copays for each 30-day supply purchased at in-network pharmacies.

Preventive Care In-Network

Includes well-baby immunizations; ages 7-adult screening tests include an annual Pap test, breast exam and mammogram for women and a prostate-specific antigen test for men.

HealthyCheck^{SM*}

Annual Health Screening

In-Network

¹ Per-family amount is aggregate, i.e., once one or more family members' eligible covered expenses (combined) meet this amount, the requirement is satisfied for all covered family members.

² Annual Out-of-Pocket Maximum: Expenses that contribute to the annual out-of-pocket maximum vary from plan to plan and have restrictions and limitations. Refer to each plan's *Combined Evidence of Coverage and Disclosure Form* or *Certificate* for full details.

³ If a member selects a brand-name drug when a generic equivalent drug is available, even if the physician writes a “dispense as written” or “do not substitute” prescription, the member will be responsible for the generic copay plus the difference in cost between the brand-name drug and the generic equivalent drug; the amount does not apply to the member's brand-name deductible.

*Must be done at a HealthyCheckSM designated facility.

Power HealthFund 500	Power HealthFund 750	Lumenos HIA Plus 3000
First-dollar coverage (limited carryover; does not apply toward annual deductible) First, the plan pays 100% of member's covered expenses up to these amounts for all covered services EXCEPT prescription drugs:		First, the plan pays 100% of member's covered expenses up to these amounts for all covered services INCLUDING prescription drugs:
Single member: \$500 Family: \$1,000 aggregate	Single member: \$750 Family: \$1,500 aggregate	Single member: \$1,000 Family: \$2,000 aggregate
Next, member pays 100% of expenses up to these amounts for covered services (before coinsurance begins)		
Single member: \$1,000 Family: \$2,000 aggregate First Dollar Coverage does not apply toward annual deductible	Single member: \$500 Family: \$1,000 aggregate First Dollar Coverage does not apply toward annual deductible	Single member: \$3,000 Family: \$6,000 aggregate Medical/pharmacy combined Health incentive allocation applies toward annual deductible First year allocation will be pro-rated for effective dates other than 1/1
Single member: \$5,000 Family: \$10,000 aggregate	Single member: \$5,000 Family: \$10,000 aggregate	Single member: \$3,000 Family: \$6,000 aggregate Medical/pharmacy combined
Plan pays maximum of \$10,000 per member; \$20,000 family aggregate	Plan pays maximum of \$10,000 per member; \$20,000 family aggregate	Single member: \$6,000 Family: \$12,000 aggregate Medical/pharmacy combined
\$40 copay after deductible	\$35 copay after deductible	0% after deductible (the deductible is waived for preventive care, which includes nationally recommended preventive care services)
50% of negotiated fee plus 100% of excess charges after deductible	50% of negotiated fee plus 100% of excess charges after deductible	30% of negotiated fee plus 100% of excess charges after deductible
40% of negotiated fee after deductible	25% of negotiated fee after deductible	0% after deductible
50% of negotiated fee plus 100% of excess charges after deductible	50% of negotiated fee plus 100% of excess charges after deductible	30% of negotiated fee plus 100% of excess charges after deductible
40% of negotiated fee after deductible	25% of negotiated fee after deductible	0% after deductible
\$10 generic; \$35 brand-name ³ (after annual \$350 brand-name prescription drug deductible per member); 30% of negotiated fee for self-administered injectable drugs, except insulin. Subject to brand-name prescription drug deductible if applicable. Up to a 60-day supply is available through mail order.	\$10 generic; \$30 brand-name ³ (after annual \$250 brand-name prescription drug deductible per member); 30% of negotiated fee for self-administered injectable drugs, except insulin. Subject to brand-name prescription drug deductible if applicable. Up to a 60-day supply is available through mail order.	0% after deductible Up to a 90-day supply is available through mail order.
\$40 office visit copay plus 40% of negotiated fee for all other covered services after deductible	\$35 office visit copay plus 25% of negotiated fee for all other covered services after deductible	0% (the deductible is waived) Includes nationally recommended preventive services
\$25 or \$75 copay health screening options; not subject to annual deductible		Not applicable (covered under preventive care benefit)

Please Note: In-network providers accept Anthem Blue Cross negotiated fee rates as payment in full for covered services. Benefits listed are based on the negotiated fee rate for in-network providers (out-of-network providers can charge more than the negotiated fee rate); benefits listed for out-of-network providers are based on customary and reasonable charges in cases of medical emergencies; when members use an out-of-network provider, they must pay the applicable copayment or coinsurance, plus any charges that exceed that allowable amount.

Looking for an ideal cost/benefit balance? Look no further. These plans waive the deductible for regular office visits — and the deductible applies to the out-of-pocket maximum. Predictable copays and conservative deductibles make these plans ideal.

Ideal Balance

PPO \$30/\$40 Copay - These plans provide comprehensive coverage with mid-range premiums, low deductibles and copays for office visits.

Advantage PPO \$25 Copay - Rich benefits, a low office visit copay, and no deductible on brand-name prescription drugs.

Annual Deductible Waived for office visits, prescription drugs and HealthyCheck benefits; applies to annual out-of-pocket maximum	
Annual Out-of-Pocket Maximum¹ Includes annual deductible	In-Network
	Out-of-Network
Office Visits Not subject to annual deductible	In-Network
	Out-of-Network
Professional Services Including maternity, diagnostic lab and X-rays after annual deductible	In-Network
	Out-of-Network
Hospital Inpatient and outpatient After annual deductible	Participating Hospitals
Prescription Drugs² Not subject to annual medical deductible; amounts shown are copays for each 30-day supply; up to a 60-day supply is available through mail order.	In-Network
Preventive Care Includes well-baby immunizations; ages 7-adult screening tests include an annual Pap test, breast exam and mammogram for women and a prostate-specific antigen test for men.	In-Network
HealthyCheck^{SM*} Annual Health Screening. Not subject to annual deductible	In-Network
Annual Physical Exam Ages 7-adult	In-Network

¹ Annual out-of-pocket maximum: Expenses that contribute to the maximum copayment limit vary from plan to plan and have restrictions and limitations. Refer to each plan's Combined Evidence of Coverage and Disclosure Form or Certificate for full details.

² Prescription drugs: If a member selects a brand-name drug when a generic-equivalent drug is available, even if the physician writes a "dispense as written" or "do not substitute" prescription, the member will be responsible for the generic copay plus the difference in cost between the brand-name drug and the generic-equivalent drug. The amount paid does not apply to the member's brand-name prescription drug deductible (PPO \$40 and \$30 Copay plans only).

³ Annual physical exam: Maximum annual benefit of \$200 is for members covered more than six months and \$100 for members covered six months or less.

*Must be done at a HealthyCheckSM designated facility.

PPO \$40 Copay	PPO \$30 Copay	Advantage PPO \$25 Copay
\$500 per member, Two-member maximum	\$500 per member, Two-member maximum	\$250 per member, Two-member maximum
\$4,500 per member, Two-member maximum	\$4,000 per member, Two-member maximum	\$3,600 per member, Two-member maximum
Anthem Blue Cross payment of \$10,000 per member's covered expenses	Anthem Blue Cross payment of \$10,000 per member's covered expenses	Anthem Blue Cross payment of \$10,000 per member's covered expenses
First 12 visits per member: \$40 copay Additional visits: 45% of negotiated fee	First 12 visits per member: \$30 copay Additional visits: 45% of negotiated fee	First 12 visits per member: \$25 copay; Additional visits: 45% of negotiated fee up to \$900 and then 10% from \$901 to \$3,600
50% of negotiated fee plus 100% of excess charges	50% of negotiated fee plus 100% of excess charges	50% of negotiated fee plus 100% of excess charges
40% of negotiated fee	30% of negotiated fee	After annual deductible 30% up to \$900, and then 10% from \$901 to \$3,600
50% of negotiated fee plus 100% of excess charges	50% of negotiated fee plus 100% of excess charges	50% of negotiated fee plus 100% of excess charges
40% of negotiated fee	30% of negotiated fee	30% up to \$900, and then 10% from \$901 to \$3,600
\$15 generic, \$25 brand-name after annual \$150 brand-name prescription drug deductible per member; 30% of negotiated fee for self-administered injectable drugs, except insulin (subject to brand-name prescription drug deductible if applicable)	\$15 generic, \$25 brand-name after annual \$150 brand-name prescription drug deductible per member; 30% of negotiated fee for self-administered injectable drugs, except insulin (subject to brand-name prescription drug deductible if applicable)	\$15 generic, \$25 brand-name; 30% of negotiated fee for self-administered injectable drugs, except insulin
\$40 office visit copay (not subject to deductible) plus 40% of negotiated fee for all other covered services (after annual deductible)	\$30 office visit copay (not subject to deductible) plus 30% of negotiated fee for all other covered services (after annual deductible)	\$25 office visit copay (not subject to deductible) plus 30% of negotiated fee for all other covered services up to \$900 and then 10% from \$901 to \$3,600 (after annual deductible)
\$25 or \$75 copay health screening options	\$25 or \$75 copay health screening options	Each year, members ages 7-adult may choose between a HealthyCheck screening or a physical exam; the deductible is waived. \$25 or \$75 copay health screening options
		OR
	Not covered	\$25 office visit copay plus 30% of negotiated fee for all other covered services up to \$900, and then 10% from \$901 to \$3,600 ³

Our HMO plans include:

- Opportunity to choose a primary care physician from over 32,000 California HMO network doctors – so chances are your employees can easily find one close to where they live or work – as well as the option to go with our Select Network, which is unique to our SelectHMO plans.
- Out-of-state coverage for emergency services – so peace of mind goes with your employees when they travel.

Simple & Consistent

Prefer to give your employees predictable costs and no paperwork? An HMO may be the way to go.

Power SelectHMO/Power \$35 SelectHMO - Our most affordable HMO plans come with a unique network of providers.

Saver HMO/Saver \$30 HMO - These plans' low premiums + high benefits = affordable solutions your employees will appreciate.

Classic HMO/Classic \$30 HMO - These plans are a traditional choice for an ideal balance of benefits and value.

HMO 100%/HMO \$25 100% - Our richest HMO benefits are included in these comprehensive plans.

	Power \$35 SelectHMO	NEW! Power SelectHMO
Maximum Lifetime In-Network Benefits		
Your Choices	Our most affordable HMO plans comes with their own network. (Note: These plans may not be offered along with any of our non-SelectHMOs.)	
Annual Medical Deductible	\$1,000 per member (Applies to inpatient and outpatient facility services, ambulatory surgical centers and dialysis centers except medical emergencies)	\$500 per member (Applies to inpatient and outpatient facility services, ambulatory surgical centers and dialysis centers except medical emergencies)
Annual Out-of-Pocket Maximum ¹	\$3,000 per single member \$6,000 per family aggregate ² deductible applies to annual out-of-pocket maximum	\$2,250 per single member \$4,500 per family aggregate ² deductible applies to annual out-of-pocket maximum
Office Visits	\$35 copay for medical group or primary care physician visits; \$50 copay for specialist and referral care visits (Not subject to deductible)	\$25 copay for medical group or primary care physician visits; \$35 copay for specialist and referral care visits (Not subject to deductible)
Professional Services Including maternity, diagnostic lab and X-rays	No charge ³	No charge ³
Hospital Inpatient and Outpatient Facility Services	20% inpatient copay after deductible 30% outpatient copay after deductible	10% inpatient copay after deductible 20% outpatient copay after deductible
Prescription Drugs ^{4,5} Amounts shown are for a 30-day retail supply; up to a 60-day supply is available through mail order (copays apply to each 30-day supply)	\$15 generic \$25 brand-name after annual \$150 brand-name prescription drug deductible per member	\$15 generic \$25 brand-name after annual \$150 brand-name prescription drug deductible per member
Network Service	Served by SelectHMO Network (not available in all counties)	

¹ Expenses that contribute to the annual out-of-pocket maximum vary from plan to plan and have restrictions and limitations. Refer to each plan's *Combined Evidence of Coverage and Disclosure Form* or *Certificate* for full details.

² Per family amount is aggregate, i.e., when one or more family member's eligible covered expenses (combined) meet this amount, the requirement is satisfied for all covered family members.

³ Maternity services are subject to an office visit copay.

⁴ 30 percent of the negotiated fee for self-administered injectable drugs, except insulin (subject to brand-name prescription drug deductible on some plans).

⁵ If a member selects a brand-name drug when a generic equivalent drug is available, even if the physician writes a "dispense as written" or "do not substitute" prescription, the member will be responsible for the generic copay plus the difference in cost between the brand-name drug and the generic equivalent drug. The amount paid does not apply to the member's brand-name deductible.

Saver \$30 HMO	NEW!	Saver HMO	Classic \$30 HMO	NEW!	Classic HMO	HMO \$25 100%	NEW!	HMO 100%
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Unlimited lifetime benefits per member

These plans' low premiums + high benefits = an affordable solution your employees will appreciate.		These plans are a traditional choice for an ideal balance of benefits and value.		Our richest HMO benefits are included in these comprehensive plans.	
\$2,500 per member (Applies to inpatient and outpatient facility services, ambulatory surgical centers and dialysis centers except medical emergencies)	\$1,500 per member (Applies to inpatient and outpatient facility services, ambulatory surgical centers and dialysis centers except medical emergencies)	None	None	None	None
\$3,000 per single member \$6,000 family aggregate ² deductible applies to annual out-of-pocket maximum	\$2,250 per single member \$4,500 family aggregate ² deductible applies to annual out-of-pocket maximum	\$2,500 per single member \$5,000 family aggregate ²	\$1,750 per single member \$3,500 family aggregate ²	\$1,750 per single member \$3,500 family aggregate ²	\$1,750 per single member \$3,500 family aggregate ²
\$30 copay for medical group or primary care physician visits; \$40 copay for specialist and referral care visits (Not subject to deductible)	\$20 copay (Not subject to deductible)	\$30 copay for medical group or primary care physician visits; \$40 copay for specialist and referral care visits	\$20 copay	\$25 copay	\$10 copay
No charge ³	No charge ³	No charge ³	No charge ³	No charge ³	No charge ³
No charge after deductible	No charge after deductible	\$500 inpatient copay 20% of outpatient copay	\$250 inpatient copay 20% outpatient copay	No charge	No charge
\$10 generic \$25 brand-name after annual \$150 brand-name prescription drug deductible per member	\$10 generic \$25 brand-name after annual \$150 brand-name prescription drug deductible per member	\$10 generic \$25 brand-name after annual \$150 brand-name prescription drug deductible per member	\$10 generic \$25 brand-name after annual \$150 brand-name prescription drug deductible per member	\$10 generic \$20 brand-name after annual \$150 brand-name prescription drug deductible per member	\$10 generic \$20 brand-name after annual \$150 brand-name prescription drug deductible per member

Served by the Anthem Blue Cross HMO (California Care Network), which is available in most counties. Employers that offer HMO coverage must choose plans from either the CaliforniaCare Network or the Power SelectHMO Network; plans from both networks may not be offered side by side.

These top-of-the-line plans feature a low deductible (just \$250) as well as rich medical benefits and liberal brand-name drug coverage. Think of them as deluxe accommodations for your health.

Superior Designs

Premier PPO \$20/\$10 Copay - These plans carry very low annual deductibles (just \$250) and no brand-name drug deductibles – making it faster than ever to enjoy rich benefits and comprehensive drug coverage. It's easy to see why these plans are called “premier.”

¹ Annual Out-of-Pocket Maximum: Expenses that contribute to the maximum copayment limit vary from plan to plan and have restrictions and limitations. Refer to each plan's Combined Evidence of Coverage and Disclosure Form or Certificate for full details.

² Prescription Drugs: Members may select a brand-name drug when a generic-equivalent drug is available if the physician writes a “dispense as written” or “do not substitute” prescription.

³ Annual Physical Exam: Maximum annual benefit: \$200 for members covered more than six months; \$100 for members covered six months or less.

*Must be done at a HealthyCheckSM designated facility.

Benefits listed are per-member costs, subject to deductible and copayments, unless otherwise stated.

Annual Deductible Waived for office visits, prescription drugs and HealthyCheck benefits; applies to annual out-of-pocket maximum	
Annual Out-of-Pocket Maximum¹ Includes annual deductible	In-Network
	Out-of-Network
Office Visits Not subject to annual deductible	In-Network
	Out-of-Network
Professional Services Including maternity, diagnostic lab and X-rays; after annual deductible	In-Network
	Out-of-Network
Hospital Inpatient and outpatient; after annual deductible	Participating Hospitals
Prescription Drugs² Not subject to annual medical deductible; amounts shown are copays for each 30-day supply; up to a 60-day supply is available through mail order.	In-Network
Preventive Care Includes well-baby immunizations; ages 7-adult screening tests include an annual Pap test, breast exam and mammogram for women and a prostate-specific antigen test for men	In-Network
Annual Options - Each year, members ages 7-adult may choose between a HealthyCheck screening or a physical exam; the deductible is waived.	
HealthyCheck^{SM*} Screening	In-Network
OR	
Physical Exam³	In-Network

Premier PPO \$20 Copay	Premier PPO \$10 Copay
\$250 per member, two-member maximum	\$250 per member, two-member maximum
\$3,000 per member, two-member maximum	\$2,500 per member, two-member maximum
\$5,000 per member, two-member maximum	\$5,000 per member, two-member maximum
First 12 visits per member: \$20 copay Additional visits: 40% of negotiated fee	First 12 visits per member: \$10 copay Additional visits: 30% of negotiated fee
40% of customary and reasonable charges, plus 100% of excess charges	30% of customary and reasonable charges, plus 100% of excess charges
20% of negotiated fee	10% of negotiated fee
40% of customary and reasonable charges, plus 100% of excess charges	30% of customary and reasonable charges, plus 100% of excess charges
20% of negotiated fee	10% of negotiated fee
\$15 generic, \$25 brand-name; 30% of negotiated fee for self-administered injectable drugs, except insulin	\$10 generic, \$20 brand-name; 30% of negotiated fee for self-administered injectable drugs, except insulin
\$20 office visit copay (not subject to deductible) plus 20% of negotiated fee for all other covered services (after annual deductible)	\$10 office visit copay (not subject to deductible) plus 10% of negotiated fee for all other covered services (after annual deductible)
\$25 or \$75 copay health screening options	\$25 or \$75 copay health screening options
OR	OR
\$20 office visit copay plus 20% of negotiated fee for all other covered services	\$10 office visit copay plus 10% of negotiated fee for all other covered services

Please note: In-network providers accept Anthem Blue Cross negotiated fee rates as payment in full for covered services. Benefits listed are based on the negotiated fee rate for in-network providers (out-of-network providers can charge more than the negotiated fee rate); benefits listed for out-of-network providers are based on customary and reasonable charges; when members use an out-of-network provider, they must pay the applicable copayment or coinsurance, plus any charges that exceed that allowable amount.

Dental. Vision. Life. Rewards. Savings. Benefits.

If you're only offering medical coverage to your employees, you're just getting part of the rewards, savings and benefits easily available to you.

- **1% medical savings** - When you purchase \$25,000 or more in life coverage along with medical, you'll save 1 percent on your medical premium* — making life insurance more affordable than ever.
- **6% life savings plus 6% dental savings** - When you purchase both \$25,000 or more in life coverage and any of our insured dental plans at the same time, you'll save 6 percent on your life premium and 6 percent on your dental premium. That's **in addition to the 1 percent savings** on your medical premium!

*.90 is the best Risk Adjustment Factor available. Your savings reflect administrative savings resulting from multi-line purchases.

Give dental coverage...and reap the rewards.

Spending just a little on a complete health care package may save you a lot, especially when dental coverage is part of the picture. We offer a variety of Dental PPO, Dental HMO and Voluntary Dental PPO and Dental HMO plans — all specifically designed for small businesses like yours. You can pick what works best for you and your employees, and be confident that you made the right choice, because all of our dental plans are easy to use and give your employees access to more than 20,000 Dental PPO and more than 5,000 Dental HMO locations in California alone. And, just like with our medical plans, the amount you contribute toward premiums is up to you...your employees pay the rest through payroll deductions.



Your Dental coverage choices

Dental PPO plans

Want to give your employees lots of choices?

Our broad range of Dental PPO plans give your employees the freedom to choose any dentist or specialist as well as enjoy discounted fees within one of the largest dental networks in California. If your employees want lots of choices and lower monthly premiums, then one of our Dental PPO plans may be just right for you.

Dental Blue® PPO plans offer more value, less hassle

We make it easy with coverage for:

- Diagnostic and preventive services like exams, cleanings and X-rays - at no cost when using an in-network provider
- Fillings at 80 percent (or even 90 percent) when using an in-network provider
- More extensive services like oral surgery, crowns and root canals
- Orthodontic services covered on most plans

And there are no waiting periods so employees can take advantage of their dental plan right away.

You get access to an industry-leading network

Dental Blue offers employees access to more dentists and specialists than most carriers on the block. Members can see any dentist they want - with the potential for lower costs when they choose an in-network dentist.

Basic, Standard and High Option Dental PPO plans

These Dental PPO plans feature:

- The freedom to choose any dentist or specialist participating in our Prudent Buyer network (no referrals needed)
- Access to quality care at discounted fees
- Coverage for both routine visits and more extensive procedures

Dental HMO

Our Dental Net* plan offers:

- More than 5,000 dentists to choose from
- Easy-to-use coverage
- No annual deductibles
- No annual maximums
- No waiting periods
- Orthodontic services for children and adults

Note: Only services received from a participating dental office are covered by our Dental Net HMO plan. *Not available in all counties

Voluntary plans

You and your employees have choices

The Voluntary plans allow you to offer quality, comprehensive dental coverage at little or no cost to your company. You choose to pay nothing or up to 49 percent of the premiums; your employees pay up to 100 percent through payroll deductions.

- The Voluntary Dental PPO plan gives employees a choice of any dentist and many services offered at a very low cost or even no cost. Diagnostic and preventive care is covered immediately after approval.
- The Voluntary Dental Saver SelectHMO plan gives employees a chance to enjoy unlimited benefits with participating dentists, low office copays, and no annual maximums or deductibles. Diagnostic and preventive care coverage begins immediately after approval.

Take a look at vision coverage... and see even more savings.

When you offer your employees Blue View VisionSM as part of a complete benefits package, the value is clear. Our cost-effective vision plans include comprehensive eye exams, fast delivery of eyewear and an attractive retail frame allowance.

Choose from two plans, Blue View and Blue View Plus.

Both feature easy-to-use benefits as well as:

- *A convenient network* - Employees have access to an extensive network of participating providers and provider locations — more than 44,000 providers and provider locations nationwide, and 4,000 in California alone. This network includes independent ophthalmologists and optometrists, as well as LensCrafters®, Target Optical, and most Sears Optical, JCPenney Optical and Pearle Vision. Many of these locations are conveniently open in the evenings and on weekends.
- *Value-added savings* - Employees enjoy additional savings of up to 40 percent on unlimited purchases of most extra pairs of eyewear, contact lenses, lens treatments, specialized lenses and various accessories — even after they've used up their covered benefits.

A little Life can go a long way.

Your employees depend on you, and their families depend on them. We make it easy for you to offer your employees competitive, affordable life insurance to help improve their families' financial security. Your employees will appreciate that you took the time to include their families' future in your company's benefits package. And, if two or more of your employees are enrolled in our medical plan(s), life coverage is "guaranteed issue" — meaning no underwriting and no forms to fill out.

When you enroll 11 or more employees in Anthem Blue Cross life coverage, you'll automatically receive a single ("composite") life rate per \$1,000 in life coverage — regardless of the age or gender of those enrolling.

A helpful, confidential program...at no additional cost.

With Life coverage of \$25,000, our LifeConnectionsSM member assistance program is included at no additional cost. Through confidential support services, 24/7 counseling by phone, and online resources, this program helps employees and their families, especially during a difficult time of loss.

We are your single solution

With Anthem Blue Cross, it's about making your benefit program easier. Simpler. And, most importantly, making it work well together. Whether it's health, dental, vision, life or workers' compensation, we're in it to help achieve healthier employees.

EmployeeElect Exclusions and Limitations

Medical Plans Exclusions & Limitations

Exclusions and Limitations Common to All Medical Plans

- Any amounts in excess of maximums stated in the Combined Evidence of Coverage and Disclosure Form/Certificate.
- Services or supplies that are not medically necessary.
- Services received before your effective date.
- Services received after your coverage ends.
- Any conditions for which benefits can be recovered under any workers' compensation law or similar law.
- Services you receive for which you are not legally obligated to pay.
- Services for which no charge is made to you in the absence of insurance coverage.
- Services not listed as covered in the Combined Evidence of Coverage and Disclosure Form/Certificate.
- Services from relatives.
- Vision care except as specifically stated in the Combined Evidence of Coverage and Disclosure Form/Certificate.
- Eye surgery performed solely for the purpose of correcting refractive defects.
- Hearing aids and routine hearing tests except as specifically stated in the Combined Evidence of Coverage and Disclosure Form/Certificate.
- Sex changes.
- Dental and orthodontic services except as specifically stated in the Combined Evidence of Coverage and Disclosure Form/Certificate.
- Cosmetic surgery.
- Routine physical examinations except as specifically stated in the Combined Evidence of Coverage and Disclosure Form/Certificate.
- Treatment of mental or nervous disorders and substance abuse (including nicotine use) or psychological testing, except as specifically stated in the Combined Evidence of Coverage and Disclosure Form/Certificate.
- Custodial care.
- Experimental or investigational services.
- Services provided by a local, state or federal government agency, unless you have to pay for them.
- Diagnostic admissions.
- Telephone or facsimile machine consultations.
- Personal comfort items.
- Nutritional counseling (PPO plans only).
- Health club memberships.
- Any services to the extent you are entitled to receive Medicare benefits for those services without payment of additional premium for Medicare coverage.
- Food or dietary supplements, except for formulas and special food products to prevent complications of phenylketonuria (PKU).
- Genetic testing for non-medical reasons or when there is no medical indication or no family history of genetic abnormality.
- Outdoor treatment programs.
- Replacement of prosthetics and durable medical equipment when lost or stolen.
- Any services or supplies provided to any person not covered under the Agreement in connection with a surrogate pregnancy.
- Immunizations for travel outside the United States.
- Services or supplies related to a pre-existing condition (PPO plans only).
- Educational Services except as specifically provided or arranged by Anthem Blue Cross.
- Infertility services (including sterilization reversal) except as specifically stated in the Combined Evidence of Coverage and Disclosure Form/Certificate.
- Care or treatment provided in a non-contracting hospital except as specifically stated in the Combined Evidence of Coverage and Disclosure Form/Certificate.
- Private duty nursing except as specifically stated in the Combined Evidence of Coverage and Disclosure Form/Certificate.
- Services primarily for weight reduction except medically necessary treatment of morbid obesity.
- Outpatient drugs, medications or other substances dispensed or administered in any outpatient setting except as specifically stated in the Combined Evidence of Coverage and Disclosure Form/Certificate.
- Contraceptive devices unless your physician determines that oral contraceptive drugs are not medically appropriate.

Additional Exclusions and Limitations

Applicable Only to the HMO plans

- Care not authorized by your PMG or IPA.
- Amounts in excess of customary and reasonable charges for care rendered by a nonparticipating provider without an authorized referral from your PMG or IPA.
- Rehabilitative care, such as physical therapy, occupational therapy and speech therapy, except as specifically stated in the Combined Evidence of Coverage and Disclosure Form.
- Treatment of the jaw or teeth secondary to malocclusion or orthognathic conditions.
- Growth hormone treatment.
- Acupuncture/acupressure.
- Durable Medical Equipment except as specifically stated in the Combined Evidence of Coverage and Disclosure Form.

Additional Exclusions and Limitations

Applicable Only to Basic PPO and Saver PPO Plans

- Physical and/or occupational therapy/medicine or chiropractic services except as specifically stated in the Certificate.
- Outpatient speech therapy.
- Footwear except as specifically stated in the Certificate.

General Provisions

Member Privacy

Our complete **Notice of Privacy Practices** provides a comprehensive overview of the policies and practices we enforce to preserve our members' privacy rights and control use of their health care information, including: the right to authorize release of information; the right to limit access to medical information; protection of oral, written and electronic information; use of data; and information shared with employers. This notice can be downloaded from our website at www.anthem.com/ca or obtained by calling Small Group Customer Service at **(800-627-8797)**.

Utilization Review

The Anthem Blue Cross Utilization Review Program helps members receive coverage for appropriate treatment in the appropriate setting. Four review processes are included: 1) Preservice Review assesses medical necessity before services are provided; 2) Admission Review determines at the time of admission if the stay or surgery is Medically Necessary in the event Preservice Review is not conducted; 3) Continued Stay Review determines if a continued stay is Medically Necessary; 4) Retrospective Review determines if the stay or surgery was Medically Necessary after care has been provided if none of the first three reviews were performed. Utilization Review is not the practice of medicine or the provision of medical care to you. Only your doctor can provide you with medical advice and medical care.

Grievances

All complaints and disputes relating to a member's coverage with Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company must be resolved in accordance with the companies' grievance procedure. You can report your grievance by phone or in writing; see your Anthem Blue Cross ID card for the appropriate contact information. All grievances received by Anthem Blue Cross /Anthem Blue Cross Life and Health Insurance Company that cannot be resolved by phone (when appropriate) to the mutual satisfaction of the member and Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company will be acknowledged in writing, together with a description of how Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company proposes to resolve the grievance. Grievances that cannot be resolved by these procedures shall be resolved as indicated through binding arbitration, or if the plan you are covered under is subject to the Employee Retirement Income Security Act of 1974 (ERISA), in compliance with ERISA rules.

If the group is subject to ERISA, and a member disagrees with the proposed resolution of a grievance, the member may submit an appeal by phone or in writing, by contacting the phone number or address printed on the letterhead of the Anthem Blue Cross response letter.

For the purposes of ERISA, there is one level of appeal. For urgent care requests for benefits, we will respond within 72 hours from the date the appeal is received. For pre-service requests for benefits, the member will receive a response within 30 calendar days from the date the appeal is received. For post-service claims, we will respond within 60 calendar days from the date the appeal is received.

If the member disagrees with Anthem Blue Cross' decision on the appeal, the member may elect to have the dispute settled through alternative resolution options, such as voluntary binding arbitration.

For Anthem Blue Cross Members

The California Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **(800-627-8797)** and use your health plan's grievance process before contacting the DMHC. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the DMHC for assistance. Your case may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency or urgent medical services. The DMHC also has a toll-free telephone number **(888-HMO-2219)**, and TDD line **(877-688-9891)** for the hearing- and speech-impaired. The department's website, hmohelp.ca.gov, has complaint forms, IMR application forms and instructions online.

For Anthem Blue Cross Life and Health Insurance Company Members

Overseeing the industry and protecting the state's insurance consumers is the responsibility of the California Department of Insurance (CDI). The CDI regulates, investigates and audits insurance business to ensure that companies remain solvent and meet their obligations to insurance policyholders. If you have a problem regarding your coverage, please contact Anthem Blue Cross Life and Health Insurance Company first to resolve the issue. If contacts between you (the complainant) and Anthem Blue Cross Life and Health Insurance Company (the Insurer) have failed to produce a satisfactory solution to the problem, you may wish to contact the CDI. They can be reached by writing to the California Department of Insurance, Consumer Affairs Bureau, 300 South Spring St. - South Tower, Los Angeles, CA 90013. The CDI also has a toll-free phone number **(800-927-HELP [43571])** that you may call for assistance.

Binding Arbitration

If the plan is subject to ERISA, any dispute involving an adverse benefit decision must be resolved under ERISA claims procedure rules, and is not subject to mandatory binding arbitration. Members may pursue voluntary binding arbitration after they have completed an appeal under ERISA rules. If the member has another dispute that does not involve an adverse benefit decision, or if the group does not provide a plan that is subject to ERISA, the following provisions apply: any and all disputes between the employer and/or the member and Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company, including but not limited to claims of medical malpractice, must be resolved by binding arbitration (not by lawsuit or trial by court or jury or other court process, except as California's law provides for judicial review of arbitration proceedings), if the amount in dispute exceeds the jurisdictional limit of the Small Claims Court. Under this coverage, both the member and Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company are giving up the right to participate in class arbitration or have any dispute decided by a court or jury trial.

Medicare

Under TEFRA/DEFRA, Medicare is the primary coverage for groups with fewer than 20 employees. Anthem Blue Cross coverage is considered primary coverage for groups of 20 or more employees. This Anthem Blue Cross coverage is not a supplement to Medicare, but provides benefits according to the non-duplication of Medicare clause.

If Medicare is a member's primary health plan, Anthem Blue Cross will not provide benefits that duplicate any benefits you are entitled to receive under Medicare. This means that when Medicare is the primary health coverage, benefits are provided in accordance with the benefits of the plan, less any amount paid by Medicare. If you are entitled to Part A or B of Medicare, you will be eligible for non-duplicate Medicare coverage, with supplemental coordination of benefits. However, if you are required to pay the Social Security Administration an additional premium for any part of Medicare, then the above policy will only apply if you are enrolled in that part of Medicare. Note: Medicare-eligible employees/dependents enrolled in plans where Medicare is primary may obtain an Individual Anthem Blue Cross Medicare Supplement plan with the pre-existing condition exclusion waived.

Coordination of Benefits

The benefits of a member's plan may be reduced if the member has other group health, dental, drug or vision coverage, so that benefits and services the member receives from all group coverages do not exceed 100 percent of the covered expense.

Third-Party Liability

If a member is injured, the responsible party may be legally obligated to pay for medical expenses related to that injury. Anthem Blue Cross may recover benefits paid for medical expenses if the member recovers damages from a legally liable third party. Examples of third-party liability situations include car accidents and work-related injuries.

Voiding Coverage for False and Misleading Information

False or misleading information or failure to submit any required enrollment materials may form the basis for voiding coverage from the date a plan was issued or retroactively adjusting the premium to what it would have been if the correct information had been furnished. No benefits will be paid for any claim submitted if coverage is made void. Premiums already paid for the time period for which coverage was rescinded will be refunded, minus any claims paid.

Incurred Medical Care Ratio

As required by law, we are advising you that Anthem Blue Cross and its affiliated companies' incurred medical care ratio for 2007 was 80.43 percent. This ratio was calculated after provider discounts were applied.

This brochure provides abbreviated information about benefits, exclusions and limitations. Please refer to the Combined Evidence of Coverage and Disclosure Forms and/or Certificates for comprehensive descriptions of coverage, benefits, special circumstances and limitations.

Call your Anthem Blue Cross agent today to find out if EmployeeElect is the right choice for you!







All Small Group HMO Medical & Dental HMO plans, Premier \$10/\$20 Copay plans and PPO \$30/\$40 Copay plans are offered by Anthem Blue Cross. All other Small Group Medical, Dental, Vision, Group Term Life and AD&D products are offered by Anthem Blue Cross Life and Health Insurance Company. Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensees of the Blue Cross Association.

Workers' Compensation coverage is provided through Employers® Compensation Insurance Company, a separate company that does not offer blue branded products or services. Administrative services for the Premium Only Plan (P.O.P.) are provided by Ceridian Benefit Services, Inc., an independent company that is not affiliated with Anthem Blue Cross, its affiliates or parent organization.

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THIS BROCHURE IS AN OVERVIEW OF COVERAGE. A COMPREHENSIVE DESCRIPTION OF COVERAGE, BENEFITS, EXCLUSIONS AND LIMITATIONS IS CONTAINED IN THE CERTIFICATES AND/OR COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORMS.

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