

We are your single solution.

A complete package gives you ultimate savings and convenience.

With Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company, it's all about making your benefits program simpler. And most importantly, making it work well together. Whether it's health, dental, vision or life coverage, we're in it to help achieve healthier employees.

Maximize your savings opportunities!
1 percent health savings* — When you purchase \$25,000 or more of life coverage along with health coverage, you may qualify for a 1 percent savings on your health premiums... making life insurance more affordable than ever.

6 percent life savings plus 6 percent dental savings — When you purchase any of our insured dental plans and \$25,000 or more of life coverage at the same time, receive a 6 percent savings on your dental premium and a 6 percent savings on your life premium.

Composite life rates — Enroll 11 or more employees in life coverage, and you'll automatically get the advantages of a single rate per \$1,000 of life.

Quite simply, you can save a lot of time and a lot of money when you purchase health, dental, vision and life coverage together from one convenient, trusted source.

With one complete package, everyone wins.

- Our complete health benefits package offers you:
- One reliable source with more than 70 years of experience, outstanding customer service and financial stability
 - One consolidated bill (which means just one premium check)
 - One more way to help make your business successful ...and some of the best savings opportunities you'll find anywhere

Plus, with EmployerAccess, you can manage your employees' dental, vision and life plans — and pay your bills — all in one seamless online experience.

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®, America's small business insurance specialist, with any of our health plans, you get an automatic 10 percent discount off the Workers' Comp portion of your monthly bill. And you can potentially save on the health portion of your bill. Be sure to ask your Anthem Blue Cross agent about this incredible opportunity!

Great ways to save!

With our lower mail-order pharmacy copays, you and your employees can save \$80 or more per year on prescription costs when you order maintenance medication through our NextRx pharmacy!** And now, ALL EmployeeElect plans offer generics at a \$10 copay and we've added coverage for brand- name nonformulary drugs to most of our plans.***

*Lowest RAF possible is .90. RAF guaranteed for one year. Savings reflect administrative savings resulting from multi-line purchases.
 ** Member pays full cost of drug at negotiated rates until deductible is met, if applicable.
 ***Brand-name drugs not available on plans with generic-only pharmacy benefits.

Health Tools

Anthem Blue Cross offers a wide range of tools to help members manage their health. Our 360° Health® is one of the industry's most comprehensive care management programs. With successful integration of health data and management tools, 360° Health offers effective engagement strategies for our members.

360° Health includes:

- Healthy Living Powered by WebMD
- Wellness Information
- AudioHealth Library
- Health Risk Assessments
- Staying Healthy Reminders
- Health Discounts
- 24/7 Nurseline
- Decision Support Tools
- MyHealth Record
- Condition Care

Our new Anthem Care Comparison allows for a side-by-side comparison of quality and cost for medical procedures in your area.

Time Well SpentSM offers tools to help create a culture of health in the workplace and raise the level of employee awareness.

Summary of HMO Coverage

From Anthem Blue Cross

This chart describes benefits in general terms and all comparisons are for in-network providers only. This is not a contract or solicitation of an application; an application for coverage is solicited only by a formal quote.

HMO PLANS										
Offered by Anthem Blue Cross	HMO \$10 100%	HMO \$25 100%	Classic \$20 HMO	Classic \$30 HMO	Classic \$40 HMO NEW!	Saver \$20 HMO	Saver \$30 HMO	Saver \$40 HMO NEW!	Select \$25 HMO	Select \$35 HMO
Maximum Lifetime In-Network Benefits	Unlimited lifetime benefits per member	Unlimited lifetime benefits per member	Unlimited lifetime benefits per member	Unlimited lifetime benefits per member	Unlimited lifetime benefits per member	Unlimited lifetime benefits per member	Unlimited lifetime benefits per member	Unlimited lifetime benefits per member	Unlimited lifetime benefits per member	Unlimited lifetime benefits per member
Your Choices	<ul style="list-style-type: none"> · No medical deductible · Low, predictable office visit copays · 100 percent coverage for inpatient and outpatient hospital services · Richest HMO plan design 		<ul style="list-style-type: none"> · No medical deductible · Moderate office visit copays · Predictable copays for inpatient admissions · Coinsurance for outpatient services 			<ul style="list-style-type: none"> · Medical deductible · Moderate office visit copays · No charge for inpatient and outpatient hospital services after deductible 			<ul style="list-style-type: none"> · Served by Select HMO Network · Separate copays for primary care physicians and specialists · Inpatient and outpatient coinsurance after medical deductible · Lowest HMO premiums 	
Annual Deductible	None	None	None			\$1,500 per member (Applies to inpatient and outpatient facility services, ambulatory surgical centers and dialysis centers, except medical emergencies)	\$2,500 per member (Applies to inpatient and outpatient facility services, ambulatory surgical centers and dialysis centers, except medical emergencies)	\$3,500 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)	\$1,000 per member (Applies to inpatient and outpatient facility services, ambulatory surgical centers and dialysis centers, except medical emergencies)
Annual Out-of-Pocket Maximum¹	\$1,750 per single member \$3,500 family aggregate ¹	\$1,750 per single member \$3,500 family aggregate ¹	\$1,750 per single member \$3,500 family aggregate ¹	\$2,500 per single member \$5,000 family aggregate ¹	\$3,500 per member \$7,000 family aggregate ¹	\$2,250 per single member \$4,500 family aggregate ¹ deductible applies to annual out-of-pocket maximum	\$3,000 per single member \$6,000 family aggregate ¹ deductible applies to annual out-of-pocket maximum	\$4,000 per single member \$8,000 family aggregate ¹ deductible applies to annual out-of-pocket maximum	\$2,250 per single member \$4,500 family aggregate ¹ deductible applies to annual out-of-pocket maximum	\$3,000 per single member \$6,000 family aggregate ¹ deductible applies to annual out-of-pocket maximum
Office Visits	\$10 copay	\$25 copay	\$20 copay	\$30 copay for primary care physician visits; \$40 copay for specialist and referral care visits	\$40 copay for primary care physician visits \$50 copay for specialist and referral care visits	\$20 copay (not subject to deductible)	\$30 copay for primary care physician visits; \$40 copay for specialist and referral care visits (not subject to deductible)	\$40 copay for primary care physician visits; \$50 copay for specialist and referral care visits (not subject to deductible)	\$25 copay for primary care physician visits; \$35 copay for specialist and referral care visits (not subject to deductible)	\$35 copay for primary care physician visits; \$50 copay for specialist and referral care visits (not subject to deductible)
Professional Services Including maternity, diagnostic lab and X-rays	No charge ² (except \$100 copay for complex radiology services obtained in a nonhospital-based facility)		No charge ² (except \$100 copay for complex radiology services obtained in a nonhospital-based facility)			No charge ² (except \$100 copay for complex radiology services obtained in a nonhospital-based facility)			No charge ² (except \$100 copay for complex radiology services obtained in a nonhospital-based facility)	
Hospital Inpatient and Outpatient Facility Services	No charge	No charge	\$250 copay per inpatient admission 20% outpatient copay	\$500 copay per inpatient admission 20% outpatient coinsurance	\$1,000 copay per inpatient admission 30% outpatient coinsurance	No charge after deductible			10% inpatient copay after deductible 20% outpatient copay after deductible	20% inpatient copay after deductible 30% outpatient copay after deductible
Prescription Drugs⁴ Amounts shown are for a 30-day retail supply; Mail-order service is available	\$10 generic; \$25 formulary brand; \$40 nonformulary brand; Self-injectable: 30% up to maximum \$100 member copay \$150 annual brand-name prescription drug deductible per member applies to all covered brand-name drugs				\$10 generic; \$25 formulary brand; \$40 nonformulary brand; Self-injectable: 30% up to maximum \$100 member copay \$250 annual brand-name prescription drug deductible per member applies to all covered brand-name drugs	\$10 generic; \$25 formulary brand; \$40 nonformulary brand; Self-injectable: 30% up to maximum \$100 member copay \$150 annual brand-name prescription drug deductible per member applies to all covered brand-name drugs		\$10 generic; \$25 formulary brand; \$40 nonformulary brand; Self-injectable: 30% up to maximum \$100 member copay \$250 annual brand-name prescription drug deductible per member applies to all covered brand-name drugs		\$10 generic; \$25 formulary brand; \$40 nonformulary brand; Self-injectable: 30% up to maximum \$100 member copay \$150 annual brand-name prescription drug deductible per member applies to all covered brand-name drugs
Network Service	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 Select HMO Network; plans from both networks may not be offered side by side.									

Notes:

¹Per 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.

²Maternity services are subject to an office visit copay.

³Anthem Blue Cross Life and Health will pay in-network and out-of-network covered services (including prescription drugs) at 100% of covered expense up to the Health Incentive Allocation (HIA). After HIA has been exhausted, the deductible must be satisfied before Anthem Blue Cross Life and Health will pay for subsequent covered services (note: in-network preventive care is not subject to the deductible). HIA will be applied toward the annual deductible. If your effective date starts in a month other than January, the amount of your HIA will be prorated based on the month of the effective date. If you do not use the full amount of your allocation by the end of the year, the unused portion, up to a specified maximum, will be carried over for use in the next year.

⁴Expenses 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* (EODC) or *Certificate* for full details.

⁵Copays listed apply when a generic equivalent is not available. 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.

⁶Members may select a brand-name drug when a generic drug is available if the physician writes, "dispense as written" or "do not substitute" prescription.

⁷Maximum annual Anthem Blue Cross payment of \$500 for members covered more than six months and \$250 for members covered six months or less, in network and out of network combined. Each family member ages 7 to adult may choose annually between a physical exam and a HealthyCheck screening.

⁸Clements Hospital Preferred, Elements Hospital Plus and Clements Hospital plans are basic hospital and limited professional benefits plans. Some covered services are limited.

EmployeeElect



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 Phone (877) 566-5454

http://www.barricksinsurance.com



With Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company, your employees get the dependable, high-quality benefits they want, while you get the pricing flexibility you need. Sit back and relax...and let EmployeeElect work for you.

anthem.com/ca



EmployeeElect Health Care Plans: You Choose

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

Helping your employees stay healthy all year long

All Small Group HMO Health & Dental plans, Premier \$10/\$20/\$30 Copay plans, PPO \$30/\$40 Copay plans, and the High Deductible EPO plan are offered by Anthem Blue Cross. All other Small Group Health, Dental, Vision, Group Term Life and ADO 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.

Summary of PPO Coverage

From Anthem Blue Cross and Anthem Blue Cross Life and Medical Insurance Company

Customize your choices. Control your costs.

With EmployeeElect, you can:

- Choose from PPO, HMO, and consumer-driven health plans
- Customize your package with a wide variety of plan designs
- Offer just one, a combination of a few, or all plans
- Control the cash flow – simply choose the contribution option that works for you, and your employees will pay the rest through payroll deductions:
 - Fixed dollar contribution – you pay \$100 or more (in \$5 increments)
 - Traditional contribution – you pay 50 percent or more
 - Percentage and plan contribution – you pay 50 percent or more, tied to a specific plan (excluding Basic PPO)
- Save even more when you add dental, vision, and life with medical
- Surround your employees with our 360° Health™ a valuable health and well-being program provided with every plan
- Rest assure your rates and benefits are guaranteed for at least one year
- Manage your coverage in one seamless online experience with EmployerAccess

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

Call your Anthem Blue Cross agent today to get started customizing your benefits package now!

	PREMIER PPO PLANS			PPO COPAY PLANS			PPO GENRX PLANS			SOLUTION PPO PLANS			LUMENOS® HIA PLUS PLANS		LUMENOS® HSA (100/70) PLANS			LUMENOS® HSA (80/50) PLANS			EPO PLANS		ELEMENTS HOSPITAL PLANS®						
	Premier PPO \$10 Copay*	Premier PPO \$20 Copay*	Premier PPO \$30 Copay* NEW!	PPO \$20 Copay** NEW!	PPO \$30 Copay*	PPO \$40 Copay*	PPO \$25 Copay GenRx** NEW!	PPO \$35 Copay GenRx**	PPO \$45 Copay GenRx**	Solution 2500 PPO**	Solution 3500 PPO**	Solution 5000 PPO**	Lumenos HIA Plus 500** NEW!	Lumenos HIA Plus 750** NEW!	Lumenos HSA 2000 (100/70)**	Lumenos HSA 3000 (100/70)**	Lumenos HSA 5000 (100/70)** NEW!	Lumenos HSA 1500 (80/50)** NEW!	Lumenos HSA 2500 (80/50)** NEW!	Lumenos HSA 3500 (80/50)** NEW!	High Deductible Exclusive Provider Organization (EPO)*	Elements Hospital** NEW!	Elements Hospital Plus** NEW!	Elements Hospital Preferred** NEW!					
Maximum Lifetime Benefits	\$5,000,000 in lifetime benefits per member			\$5,000,000 in lifetime benefits per member			\$5,000,000 in lifetime benefits per member			\$5,000,000 in lifetime benefits per member			\$5,000,000 in lifetime benefits per member		\$5,000,000 in lifetime benefits per member			\$5,000,000 in lifetime benefits per member			\$5,000,000 in lifetime benefits per member		\$5,000,000 in lifetime benefits per member						
Your Choices	<ul style="list-style-type: none"> Low medical deductible Customary and reasonable nonpar benefits No brand-name drug deductible Richest PPO plan design 			<ul style="list-style-type: none"> Mid-range premiums Moderate deductible and office visits copay Low brand-name drug deductible Preventive care coverage 			<ul style="list-style-type: none"> Affordable premiums Comprehensive medical benefits Generic-only drug benefit Preventive care coverage 			<ul style="list-style-type: none"> Lower premiums Predictable office visits and prescription drug copays Preventive care coverage 			<ul style="list-style-type: none"> Funds for first dollar coverage Health incentive programs to promote well being 100 percent preventive care coverage 		<ul style="list-style-type: none"> 100 percent medical coverage after deductible Predictable prescription copays after the deductible is met HSA-compatible plan design 100 percent preventive care coverage 		<ul style="list-style-type: none"> 80 percent medical coverage after deductible Predictable prescription copays after the deductible is met HSA-compatible plan design 100 percent preventive care coverage 			<ul style="list-style-type: none"> In-network PPO benefits only Combined medical and pharmacy deductible HSA-compatible plan design 		<ul style="list-style-type: none"> Basic hospital coverage Limited office visit and professional services coverage on Plus and Preferred plans Generic-only drug benefit (except Preferred plan) Preventive care coverage 							
Annual Deductible	\$250 per member Two-member maximum	\$250 per member Two-member maximum	\$500 per member Two-member maximum	\$250 per member Two-member maximum	\$500 per member Two-member maximum	\$750 per member Two-member maximum	\$250 per member Two-member maximum	\$500 per member Two-member maximum	\$750 per member Two-member maximum	\$2,500 per member; Two-member maximum	\$3,500 per member; Two-member maximum	\$5,000 per member; Two-member maximum	Health Incentive Plan Allocation: ² \$500 per single member \$1,000 family aggregate ¹ Annual deductible accrues after HIA funds exhausted: \$2,000 per single member \$4,000 family aggregate ¹ Medical/pharmacy combined	Health Incentive Plan Allocation: ² \$750 per single member \$1,500 family aggregate ¹ Annual deductible accrues after HIA funds exhausted: \$2,000 per single member \$4,000 family aggregate ¹ Medical/pharmacy combined	\$2,000 per single member \$4,000 family aggregate ¹ Medical/pharmacy combined	\$3,000 per single member \$6,000 family aggregate ¹ Medical/pharmacy combined	\$5,000 single member; \$10,000 family aggregate ¹ Medical/pharmacy combined	\$1,500 per single member \$3,000 family aggregate ¹ Medical/pharmacy combined	\$2,500 per single member \$5,000 family aggregate ¹ Medical/pharmacy combined	\$3,500 per single member \$7,000 family aggregate ¹ Medical/pharmacy combined	\$2,000 per single member \$4,000 family aggregate ¹ Medical/pharmacy combined	\$1,250 per member Two-member maximum	\$1,000 per member Two-member maximum	\$750 per member Two-member maximum					
Annual Out-of-Pocket Maximum* Includes deductible unless noted	\$2,500 per member Two-member maximum	\$3,000 per member Two-member maximum	\$3,500 per member Two-member maximum	\$3,500 per member Two-member maximum	\$4,000 per member Two-member maximum	\$4,500 per member Two-member maximum	\$3,500 per member; Two-member maximum	\$4,000 per member; Two-member maximum	\$4,500 per member; Two-member maximum	\$5,000 per member; Two-member maximum	\$5,000 per member; Two-member maximum	\$7,500 per member; Two-member maximum	\$5,000 per single member \$10,000 family aggregate ¹ Medical/pharmacy combined	\$5,000 per single member \$10,000 family aggregate ¹ Medical/pharmacy combined	\$4,000 per single member \$8,000 family aggregate ¹ Medical/pharmacy combined	\$5,000 per single member \$10,000 family aggregate ¹ Medical/pharmacy combined	\$5,800 per single member \$11,600 family aggregate ¹ Medical/pharmacy combined	\$3,000 per single member \$6,000 family aggregate ¹ Medical/pharmacy combined	\$5,000 per single member \$10,000 family aggregate ¹ Medical/pharmacy combined	\$5,000 per single member \$10,000 family aggregate ¹ Medical/pharmacy combined	\$3,100 per single member \$5,700 family aggregate ¹ Medical/pharmacy combined	\$2,500 plus deductible, per member; Two-member maximum	\$2,500 plus deductible, per member; Two-member maximum	\$2,500 plus deductible, per member; Two-member maximum					
Office Visits	\$10 copay (not subject to deductible)	\$20 copay (not subject to deductible)	\$30 copay (not subject to deductible)	\$20 copay (not subject to deductible)	\$30 copay (not subject to deductible)	\$40 copay (not subject to deductible)	\$25 copay (not subject to deductible)	\$35 copay (not subject to deductible)	\$45 copay (not subject to deductible)	\$25 copay (not subject to deductible)	\$35 copay (not subject to deductible)	\$40 copay (not subject to deductible)	40% after HIA and deductible	25% after HIA and deductible	0% after deductible	0% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible	Not covered	50% plus excess charges, for first \$1,000 of covered expenses; maximum Anthem payment of \$750 per year (not subject to deductible)	50% plus excess charges, for first \$1,500 of covered expenses; maximum Anthem payment of \$750 per year (not subject to deductible)	50% plus excess charges, for first \$1,500 of covered expenses; maximum Anthem payment of \$750 per year (not subject to deductible)				
Professional Services Including maternity, diagnostic lab and X-rays	10% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible	40% after deductible	25% after deductible	35% after deductible	45% after deductible	25% after deductible	35% after deductible	40% after deductible	40% after deductible	25% after deductible	0% after deductible	0% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible	Not covered	50% plus excess charges for first \$1,000 of covered expense, maximum Anthem payment of \$500 per year (not subject to deductible)	50% plus excess charges, for first \$1,500 of covered expenses; maximum Anthem payment of \$750 per year (not subject to deductible)	50% plus excess charges, for first \$1,500 of covered expenses; maximum Anthem payment of \$750 per year (not subject to deductible)				
Hospital Inpatient	10% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible	40% after deductible	25% after deductible	35% after deductible	45% after deductible	25% after deductible	35% after deductible	40% after deductible	40% after deductible	25% after deductible	0% after deductible	0% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible	30% after deductible	30% after deductible	30% after deductible	30% after deductible	30% after deductible	30% after deductible		
Prescription Drugs Amounts shown are for a 30-day retail supply; Mail-order service is available	\$10 generic \$25 formulary brand ³ \$40 nonformulary brand ³ Self-injectable: 30% up to maximum \$100 member copay			\$10 generic \$30 formulary brand ³ \$45 nonformulary brand ³ Self-injectable: 30% up to maximum \$100 member copay; \$150 annual brand-name prescription drug deductible per member applies to all covered brand-name drugs			\$10 generic Self-injectable: \$30 up to maximum \$100 member copay (GenRx Prescription Drug Formulary only)			\$10 generic Self-injectable: \$25 formulary brand ³ \$50 nonformulary brand ³ Self-injectable: 30% up to maximum \$100 member copay \$250 annual brand-name prescription drug deductible per member		\$10 generic Self-injectable: \$35 formulary brand ³ \$50 nonformulary brand ³ Self-injectable: 30% up to maximum \$100 member copay \$250 annual brand-name prescription drug deductible per member applies to all covered brand-name drugs		After HIA and deductible: \$10 generic \$30 formulary brand ³ \$50 nonformulary brand ³ Self-injectable: 30% (no maximum)		After deductible: \$10 generic \$30 formulary brand ³ \$50 nonformulary brand ³ Self-injectable: 30% (no maximum)			After deductible: \$10 generic \$30 formulary brand ³ \$50 nonformulary brand ³ Self-injectable: 30% (no maximum)			After deductible: \$10 generic Self-injectable: 30% (no maximum)		\$10 generic Self-injectable: 30% up to maximum \$100 member copay (GenRx Prescription Drug Formulary only)		\$10 generic Self-injectable: 30% up to maximum \$100 member copay (GenRx Prescription Drug Formulary only)		\$10 generic Self-injectable: 30% up to maximum \$100 member copay \$250 annual brand-name prescription drug deductible per member applies to all covered brand-name drugs	
Preventive Care For Well-Baby and Well-Child exams (for children through age 6) and adult screenings, such as Pap smear, mammogram, prostate specific antigen, and colorectal cancer screenings	\$10 office visit copay (not subject to deductible) plus 10% after deductible for all other covered services beyond that related office visit	\$20 office visit copay (not subject to deductible) plus 20% after deductible for all other covered services beyond that related office visit	\$30 office visit copay (not subject to deductible) plus 30% after deductible for all other covered services beyond that related office visit	\$20 office visit copay (not subject to deductible) plus 20% after deductible for all other covered services beyond that related office visit	\$30 office visit copay (not subject to deductible) plus 30% after deductible for all other covered services beyond that related office visit	\$40 office visit copay (not subject to deductible) plus 40% after deductible for all other covered services beyond that related office visit	\$25 office visit copay (not subject to deductible) plus 25% after deductible for all other covered services beyond that related office visit	\$35 office visit copay (not subject to deductible) plus 35% after deductible for all other covered services beyond that related office visit	\$45 office visit copay (not subject to deductible) plus 45% after deductible for all other covered services beyond that related office visit	\$25 office visit copay (not subject to deductible) plus 25% after deductible for all other covered services beyond that related office visit	\$35 office visit copay (not subject to deductible) plus 35% after deductible for all other covered services beyond that related office visit	\$40 office visit copay (not subject to deductible) plus 40% after deductible for all other covered services beyond that related office visit	0% (Includes nationally recommended preventive care services (not subject to deductible))	0% (Includes nationally recommended preventive care services (not subject to deductible))	0% (Includes nationally recommended preventive care services (not subject to deductible))	0% (Includes nationally recommended preventive care services (not subject to deductible))	0% (Includes nationally recommended preventive care services (not subject to deductible))	0% (Includes nationally recommended preventive care services (not subject to deductible))	0% (Includes nationally recommended preventive care services (not subject to deductible))	0% (Includes nationally recommended preventive care services (not subject to deductible))	0% (Includes nationally recommended preventive care services (not subject to deductible))	20% after deductible	30% after deductible	30% after deductible	20% after deductible	30% after deductible	30% after deductible	20% after deductible	
HealthyCheck™ Two levels of annual medical screenings, including lab work and immunizations; must be done at a HealthyCheck Center	\$25 or \$75 copay options (not subject to deductible)	\$25 or \$75 copay options (not subject to deductible)	\$25 or \$75 copay options (not subject to deductible)	\$25 or \$75 copay options (not subject to deductible)	\$25 or \$75 copay options (not subject to deductible)	\$25 or \$75 copay options (not subject to deductible)	\$25 or \$75 copay options (not subject to deductible)	\$25 or \$75 copay options (not subject to deductible)	\$25 or \$75 copay options (not subject to deductible)	Not applicable (covered under preventive care)			Not applicable (covered under preventive care)		Not applicable (covered under preventive care)			Not applicable (covered under preventive care benefit)			\$25 or \$75 copay options (not subject to deductible)	\$25 or \$75 copay options (not subject to deductible)	\$25 or \$75 copay options (not subject to deductible)	\$25 or \$75 copay options (not subject to deductible)	\$25 or \$75 copay options (not subject to deductible)	\$25 or \$75 copay options (not subject to deductible)	\$25 or \$75 copay options (not subject to deductible)	\$25 or \$75 copay options (not subject to deductible)	
Annual Physical Exam Ages 7 to adult	OR Not subject to deductible. \$10 office visit copay plus 10% for all other covered services beyond that related office visit. ⁷	OR Not subject to deductible. \$20 office visit copay plus 20% for all other covered services beyond that related office visit. ⁷	OR Not subject to deductible. \$30 office visit copay plus 30% for all other covered services beyond that related office visit. ⁷	OR Not subject to deductible. \$20 office visit copay plus 20% for all other covered services beyond that related office visit. ⁷	OR Not subject to deductible. \$30 office visit copay plus 30% for all other covered services beyond that related office visit. ⁷	OR Not subject to deductible. \$40 office visit copay plus 40% for all other covered services beyond that related office visit. ⁷	OR Not subject to deductible. \$25 office visit copay plus 25% for all other covered services beyond that related office visit. ⁷	OR Not subject to deductible. \$35 office visit copay plus 35% for all other covered services beyond that related office visit. ⁷	OR Not subject to deductible. \$45 office visit copay plus 45% for all other covered services beyond that related office visit. ⁷	OR Not subject to deductible. \$25 copay for office visit plus 25% for all other services beyond that related office visit. ⁷	OR Not subject to deductible. \$35 copay for office visit plus 35% for all other services beyond that related office visit. ⁷	OR Not subject to deductible. \$40 copay for office visit plus 40% for all other services beyond that related office visit. ⁷	0% (Includes nationally recommended preventive care services (not subject to deductible))	0% (Includes nationally recommended preventive care services (not subject to deductible))	0% (Includes nationally recommended preventive care services (not subject to deductible))	0% (Includes nationally recommended preventive care services (not subject to deductible))	0% (Includes nationally recommended preventive care services (not subject to deductible))	0% (Includes nationally recommended preventive care services (not subject to deductible))	0% (Includes nationally recommended preventive care services (not subject to deductible))	0% (Includes nationally recommended preventive care services (not subject to deductible))	0% (Includes nationally recommended preventive care services (not subject to deductible))	Not covered	OR Not subject to deductible. 30% for office visit and covered services ⁷	OR Not subject to deductible. 30% for office visit and covered services ⁷	OR Not subject to deductible. 20% for office visit and covered services ⁷	OR Not subject to deductible. 20% for office visit and covered services ⁷	OR Not subject to deductible. 20% for office visit and covered services ⁷	OR Not subject to deductible. 20% for office visit and covered services ⁷	OR Not subject to deductible. 20% for office visit and covered services ⁷

All benefit comparisons are for in-network providers. All benefits are subject to applicable deductible(s) or payment(s). 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. Please note that 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). When members use an out-of-network provider, they must pay the applicable copayment or coinsurance, plus any charges that exceed that allowable amount.