

BeneFits



Health · Pharmacy · Dental · Vision · Life



BeneFits Health Care Plans

Designed for businesses with 2-50 employees
Just the right fit for your business
Effective April 1, 2013



Easier to afford.
Easier to qualify.
Easier to enroll.

BeneFits from Anthem Blue Cross... just the right fit for your business.

Have you considered health coverage for your business but run into roadblocks?

Consider them gone.

Our BeneFits portfolio keeps health coverage simple and affordable for small businesses just like yours. Whether you have two employees or 50, we invite you to try BeneFits on for size.

Ready to say “goodbye” to roadblocks and “hello” to simplicity and savings?

- You only need 60% of your employees to enroll in order to qualify for the many advantages of health coverage. The chart shows just how easy that can be!
- Your contribution to each employee's monthly premium can be as low as 25% or – if you'd rather pay a flat dollar amount – as low as \$50.
- When you add life coverage or both life and dental, you can actually save money on your premiums – making valuable coverage more affordable than ever.

Use this guide to check out our five BeneFits plans. And feel free to call your Anthem Blue Cross agent at any time for more details. Because everyone deserves a good fit.

A good fit should feel comfortable.

As you move forward with the day-to-day challenges of your business, this simple and affordable health coverage should fit right in.

When you select BeneFits, you get:

- Five health plans with different deductibles and a range of benefits.
- Control over your cash flow, because you choose either a traditional contribution of a percentage of premium (as low as 25%) or a fixed dollar contribution (as low as \$50) — and your employees pay the rest through payroll deductions.
- Guaranteed rates and benefits for one year (along with guaranteed coverage).
- Tax advantages for your company.
- The option to cover part-time and/or seasonal workers.
- Our interactive 360° Health® program.
- The ability to manage your coverage in one seamless online experience with EmployerAccess.

Fewer employees need to participate

For the BeneFits program, required participation is only 60% of eligible employees. Anthem Blue Cross also gives participation waivers for employees who don't want to participate for allowable reasons. Here's an example that shows how that might work for a small business with eight employees (including owner):

TOTAL EMPLOYEES	8
Waive those who don't participate for allowable reasons:	
one employee already has coverage through MediCal	-1
one employee is covered by spouse's employer group plan	-1
ELIGIBLE EMPLOYEES	6
Subtract those who don't participate for other reasons:	
one wants to keep existing individual plan instead	-1
one just doesn't want to participate	-1
ELIGIBLE ENROLLING EMPLOYEES	4

To calculate required participation, the number of eligible enrolling employees is divided by the number of eligible employees, resulting in a participation percentage. In this example:

Eligible Enrolling Employees	or	4
Eligible Employees		6

With the BeneFits program, this group meets the 60% participation requirement.

You're an expert in your business – you shouldn't have to be an expert in health coverage, too.

In larger companies, there's usually a full-time person on staff with the experience (and time) to handle health coverage for your employees. But what if you don't have a lot of experience with health coverage?

Five simple plans. Seven smart reasons to offer them.

1

BeneFits makes it affordable. Contact your local agent for more information.

2

It's all about sharing. You don't have to fund the entire cost. You can share the premiums with your employees.

3

Give yourself a tax break. Did you know that your coverage contributions can be 100% tax-deductible as business expenses on both your federal and state income taxes? And you may get to deduct other coverage-related costs such as contributions made to your employees' health savings accounts. Consult your tax professional for more information.





You want to keep the employees you've got. Offer health benefits, and your most valued employees are more likely to stick around.

4

5

Because people wear so many big hats in a small business, one employee calling in sick can send everyone scrambling. Providing health coverage keeps employees more productive because it can help to keep them healthier.

6

How many people work in your business? Two (including you) is all it takes for small business health coverage.

7

Very few things are guaranteed. If you're a qualifying California business, you're guaranteed coverage — regardless of the health history of any employees. Also, you cannot be charged more than 10% over the standard rate — and you actually might pay up to 10% **under** the standard rate.

Starting to sound like a good fit?

Helpful Definitions

Annual Deductible — the amount you have to pay first, before your health plan starts to pay.

Annual Out-of-Pocket Maximum — the most you pay in any one calendar year for qualified in-network covered services before your plan pays 100% of your eligible covered costs for the rest of the year (you will pay more for out-of-network services).

Coinsurance — the percentage you pay when you receive covered services.

Copay — the dollar amount you pay during an office visit when you see the doctor or receive another covered service.

Two-Family-Member Maximum — two covered members of the family must meet this amount separately to satisfy the requirement for all covered family members.

Family Aggregate — all covered family members' eligible expenses can be combined to satisfy the family maximum requirement.

Generic Drug — an identical drug to its brand-name equivalent in active ingredient, dosage form, strength, quality and intended uses, as well as its physiological and pharmacological effect.

In-Network — an in-network doctor, dentist, specialist, hospital or pharmacy has a contract with Anthem Blue Cross to provide our members with services at a reduced fee. If you go out-of-network, you pay more.

HMO — a "Health Maintenance Organization" offers comprehensive health care to enrolled members in a particular geographic area, through doctors in its network who make referrals to specialists when medically necessary.

PPO — a "Preferred Provider Organization" is a health insurance plan that lets members receive more coverage if they choose health care providers in the plan's network.

HSA — a "Health Savings Account" can be funded by your own pre-tax contributions. Others can also contribute money to your HSA on your behalf. You can use money in your HSA to pay for your health care, including prescriptions when enrolled in an HSA-compatible plan.

For a good fit, you need choices. And here they are.

Take a glance at our five sensational plans. And if the plan fits...

The descriptions of our BeneFits plans that follow show the amounts that members are responsible for paying for covered in-network services. When you choose BeneFits from Anthem Blue Cross, you decide how many of the plans to offer your employees. You can offer all or just one — it's your choice.

Hospital BeneFits Preferred

This affordable PPO plan features hospital-only benefits, access to generic-only prescription drugs, even more benefits (including some doctor visits at an even lower deductible), plus basic dental and vision.

Hospital BeneFits Plus

This affordable PPO plan provides hospital-only coverage, a lower deductible, enhanced benefits (including some doctor visits), and access to generic-only prescription drugs.

PPO \$35 Copay GenRx

This PPO plan provides comprehensive coverage with a generic-only drug benefit to help keep premiums affordable.

Select \$25 HMO

Our Select HMO plan works well for those wanting simplified decision-making and predictable out-of-pocket costs. The Select HMO plan utilizes a unique network of primary care physicians in 23 California counties. (Note that the Select Network is not available in all counties).

Lumenos® HSA 2500 (80/50)

This HSA-compatible plan offers 100% preventive care coverage, 80% health coverage and predictable prescription copays after the deductible is met.

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
- And more

Gain more control and enjoy the benefits of managing your health, dental, vision and life coverage in one seamless online experience.



A single solution that works smarter

When you package Anthem's dental, vision and life benefits with your health plan, you get a comprehensive benefits program that works smarter. Our enhanced dental, vision and life benefits deliver more to improve the overall health of your business and employees.

Plus, when you add life coverage to your health plan, you may actually save money on your premiums — making this valuable coverage more affordable than ever.

Find out more about our dental, vision and life products by visiting [anthem.com/specialty](https://www.anthem.com/specialty).



Why offer a PPO?

PPO means preferred provider organization. With a PPO your employees can choose any doctor, specialist or hospital they want in our large network. They can also go outside our network, but if they do their out-of-pocket costs will be higher. Generally the monthly premiums for PPO plans are lower than for other plans. Monthly premiums can be even lower with some PPOs, such as those that offer generic-only prescription drug coverage.

Our PPO plans feature:

- Access to more than 59,000 California PPO network doctors and specialists and more than 300 acute care hospitals — so chances are your employees' doctors are in our network.
- Money 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.
- Unlimited in lifetime benefits per member.
- 100% preventive benefits coverage when seen in-network.

Why offer an HMO?

HMO stands for health maintenance organization. With an HMO, your employees choose a primary care physician who oversees their health care and provides referrals to specialists when needed. Generally, employees' out-of-pocket health care costs with an HMO plan are more predictable than with a PPO plan.

Our Select \$25 HMO plan includes:

- Access to a unique network of more than 7,900 primary care physicians and over 14,000 specialists in 22 California counties. This convenient network is designed to be close to where your employees live and work. (Note that the Select HMO Network is not available in all counties.)
- Out-of-state coverage for emergency services — so peace of mind goes with your employees when they travel.
- Unlimited lifetime benefits per member.

Interested in an HSA-compatible plan?

HSA is short for health savings account. Our Lumenos HSA 2500 (80/50) plan is a high-deductible plan that is teamed with an HSA. Your employees can use an HSA to pay for their health care expenses and get tax advantages.

Of course, we recommend that they talk to their tax advisor for all the details. For your employees' convenience, we've aligned with Bank of New York Mellon Bank so they can apply for our HSA-compatible plan and an HSA bank account at the same time ... or they can set up an HSA bank account at a separate financial institution they choose.

Our Lumenos HSA 2500 (80/50) plan offers all the advantages of our PPO plans, including access to our vast PPO network.



Plan Comparison and Overview

*Offered by Anthem Blue Cross
Life and Health Insurance Company

**Offered by Anthem Blue Cross

	Hospital Benefits Preferred ^{†6}								
Maximum Lifetime Benefits									
Your Choices	This affordable PPO plan features hospital-only benefits, access to generic-only prescription drugs and benefits at an even lower deductible – plus basic dental and vision.								
Annual Deductible First you pay for eligible covered charges up to this amount, and then plan benefits begin	\$1,250 per single member; \$2,500 per family ¹								
Hospital Inpatient and Outpatient Facility Services	30% after deductible								
Annual Out-of-Pocket Maximum² The most a member pays in a year for qualified covered services before plan pays 100% for most in-network services. Certain member payments do not apply.	\$5,000 per member; \$10,000 per family ¹								
Prescription Drugs The in-network amount shown is the copay for a 30-day retail supply.	<table border="0"> <tr> <td>Generic</td> <td>\$5</td> </tr> <tr> <td>Generic self-injectables</td> <td>30% of prescription up to a maximum of \$500</td> </tr> <tr> <td>Generic Prescription</td> <td>\$5</td> </tr> <tr> <td>Generic \$</td> <td>\$5</td> </tr> </table>	Generic	\$5	Generic self-injectables	30% of prescription up to a maximum of \$500	Generic Prescription	\$5	Generic \$	\$5
Generic	\$5								
Generic self-injectables	30% of prescription up to a maximum of \$500								
Generic Prescription	\$5								
Generic \$	\$5								
Doctor Office Visits	50% (not subject to deductible)								
Other Professional Services	30% after deductible related to covered hospital charges only								
Preventive Care⁴ This includes physical exams, preventive screenings and additional preventive care for women provided for in the guidelines supported by the Health Resources and Services Administration.	No copay (not subject to deductible)								
Physical Therapy, Occupational Therapy and Chiropractic Services	Not covered								
Dental Coverage	Two free cleanings and up to \$500 benefit ⁵ after \$25 deductible								
Vision Coverage	Comprehensive Blue View Vision SM coverage is included.								

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits. This summary of benefits, as updated, is subject to the approval of the California Department of Insurance and the California Department of Managed Health Care (as applicable).

Hospital Benefits Plus ⁶	PPO \$35 Copay GenRx ⁶	Lumenos ⁶ HSA 2500 (80/50)**	Select \$25 HMO**
Unlimited lifetime benefits per member			
This affordable PPO plan provides hospital-only coverage, a lower deductible, enhanced benefits (including doctor visits) and access to generic-only prescription drugs.	This innovative generic-only drug benefit design keeps premiums low and benefits high.	This HSA-compatible health plan offers 100% coverage for preventive care and is compatible with a tax-advantaged HSA.	This is a comprehensive HMO plan available in over 22 California counties, with predictable costs and unlimited lifetime coverage.
\$1,500 per single member; \$3,000 per family ¹	\$500 per member; Once 2 family members meet their deductible, the deductible is met for the family.	\$2,500 per single member; \$5,000 family aggregate ¹ Health/pharmacy combined	\$500 per member
30% after deductible	35% after deductible	20% after deductible	10% after deductible (Inpatient) 20% after deductible (Outpatient)
\$5,000 per member; \$10,000 per family ¹	\$4,500 per member; once 2 family members meet their maximum, the maximum is met for the family	\$5,000 per member; \$10,000 per family aggregate ¹ health/pharmacy combined	\$2,250 per member; \$4,500 per family aggregate ¹
Drug Formulary Only 15 copay Prescription drug maximum allowed amount \$150 per fill	GenRx Prescription Drug Formulary Only Generic \$10 copay Generic self-injectables 30% of prescription drug maximum allowed amount up to a maximum \$150 per fill	After combined health/pharmacy deductible: Tier 1 \$10 Tier 2 \$30³ Tier 3 \$50³ Tier 4 30% of prescription drug maximum allowed amount	Generic \$10 Brand-name formulary \$25 ³ Brand-name nonformulary \$40 ³ Self-injectables (except insulin) 30% of prescription drug maximum allowed amount up to a maximum \$100 per fill
50% (not subject to deductible)	\$35 copay (not subject to deductible)	20% after deductible	\$25 copay for primary care physician visits \$35 copay for specialist or referral care visits (includes office visits for maternity) not subject to deductible
30% after deductible related to covered hospital charges only	35% after deductible (includes maternity, diagnostic lab and X-rays)	20% after deductible	No charge, ⁴ except \$100 copay for complex radiology services (MRI/CT/CAT/PET/nuclear cardiac) not subject to deductible
No copay (not subject to deductible)	No copay (not subject to deductible)	0% (not subject to deductible)	No copay (not subject to deductible)
Not covered	35% after deductible	20% after deductible	20% after deductible
Stand-alone coverage is available.	Stand-alone coverage is available.	Stand-alone coverage is available.	Stand-alone coverage is available.
Stand-alone coverage is available.	Stand-alone coverage is available.	Stand-alone coverage is available.	Stand-alone coverage is available.

All benefit comparisons are for in-network providers. All benefits are subject to applicable deductible(s) or copay(s) unless otherwise noted. 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. In-network benefits are based on negotiated fee rate. Benefits for out-of-network may be based on negotiated fee or maximum allowed amount. 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 copay or coinsurance, plus any charges that exceed that allowable amount.

- 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. For Hospital Benefits Preferred and Hospital Benefits Plus, the family deductible or out-of-pocket maximum is met for the entire family when two or more family members' eligible covered expenses (combined) meet this amount, except one member cannot meet more than the individual amount.
- 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 a generic copay plus the difference in cost between the brand-name drug and the generic-equivalent drug.
- 4 Maternity services are subject to an office visit copay.
- 5 Dental and vision benefit amounts cover Anthem Blue Cross payments for eligible expenses only as outlined in the Certificate.
- 6 Benefits Hospital Preferred and Benefits Hospital Plus plans exclude coverage for services such as, but not limited to: physical therapy, occupational therapy, chiropractic care, speech therapy, durable medical equipment (except diabetes equipment and supplies, equipment related to infusion therapy, special footwear, prosthetics, orthotics are covered), outpatient professional services, laboratory work or X-rays for the treatment of infertility. There are certain limitations for benefits, such as, but not limited to: ambulance has a limited benefit per trip. Request a copy of the Certificate for comprehensive details on covered services, limitations and exclusions.

Enjoy the convenience of a single solution!

When you purchase health, dental, vision and life from Anthem, you experience the convenience of:

- Streamlined enrollment. Only one application for all four products for you and your employees.
- Pay for all four lines of coverage on one combined bill.
- Manage your health, dental, vision and life benefits through EmployerAccess, our employer website.

When you purchase health coverage and \$25,000 or more of life insurance from Anthem, you receive 1% savings on your health premium.¹

Dental plans you and your employees can smile about.

Our BeneFits portfolio includes dental PPO and DHMO plans to choose from:

Dental Blue® BeneFits Plan

Our Dental Blue PPO plan offers:

- Diagnostic and preventive services like exams, cleanings and X-rays available at no cost when using an in-network provider.
- Fillings covered at 80% when using an in-network provider.
- This dental plan has an annual maximum of \$500. Once members meet the annual maximum, they can receive our negotiated rates on additional covered services received from in-network providers.
- Dental Blue members who are pregnant or living with diabetes can receive one extra dental cleaning or periodontal maintenance procedure a year. And we'll also reach out to them with our Future Moms and ConditionCare: Diabetes programs if they are enrolled in the 360° Health® program.

Dental Net® DHMO Plans

Our Dental Net DHMO plans offer:

- No annual maximums² and no deductibles.
- No waiting periods.
- Low or no copays for nearly 300 different services, including:
 - Cleanings, exams and X-rays
 - Composite (tooth-colored) fillings on *any* tooth
 - Orthodontic services for both children and adults
- 8,000 general dentist and specialist access points throughout California.

Additional dental plans, including voluntary dental options, are available. For more information, contact your broker or Anthem representative.

Emergency dental services for the international traveler.

All Anthem dental members and their eligible, covered dependents automatically have access to the International Emergency Dental Program.³ With this program, members have access to emergency dental services through our list of credentialed, English-speaking dentists while traveling or working nearly anywhere in the world.

¹ Lowest RAF possible is .90. Your savings reflect administrative savings resulting from multi-line purchases.

² There is no maximum or age limitation for pediatric dentistry performed by your participating dental office. If in the professional judgment of your participating dentist or in professional review by plan it is determined that the participating dentist is unable to render care to a child, referral to a pediatric dentist would be a benefit under the age of five with a \$750 maximum. Exceptions are made on a pre-approval basis only.

³ The International Emergency Dental Program is managed by DeCare Dental. DeCare Dental is an independent company offering dental management services to Anthem BlueCross.

Dental Blue Benefits plan

This is an overview of coverage. A comprehensive description of coverage, benefits, exclusions and limitations is contained in the Combined Evidence of Coverage and Disclosure Form.

Dental coverage offered by Anthem Blue Cross Life and Health Insurance Company (the Dental Blue 200 network includes more than 30,000 dental access points in California)

PLAN pays amounts shown		
	In-Network	Out-of-Network
Annual Maximum Paid by Plan	\$500	
Annual Deductible Per member/three-member family maximum The member must pay this first, before plan benefits begin	\$25/\$75 Deductible waived for in-network diagnostic and preventive procedures	
Diagnostic & Preventive Services		
Teeth Cleaning – adult	100%	\$39
Teeth Cleaning – child		\$30
Oral Exams		
Periodic oral exam	100%	\$18
Initial oral exam		\$25
X-Rays		
Full mouth – complete series	100%	\$60
Bitewing – single film		\$16
Minor Services		
Fillings – amalgam (two surfaces, primary or permanent)	80%	\$55
Fillings – resin (two surfaces, anterior)		
Fillings – resin (two surfaces, posterior, primary)		
Oral Surgery		
Extraction – Impacted tooth, complete bony	Not covered	
Endodontic Services		
Root canal therapy – (molar, three or four canals)	Not covered	
Peridontic Services		
Scaling (root planting)	Not covered	
Removable Prosthodontics		
Dentures – complete (maxillary)	Not covered	
Fixed Prosthodontics		
Crowns – porcelain (high noble)	Not covered	
Orthodontics		
Adult (age 18 and over)	Not covered	
Child (through age 17)		

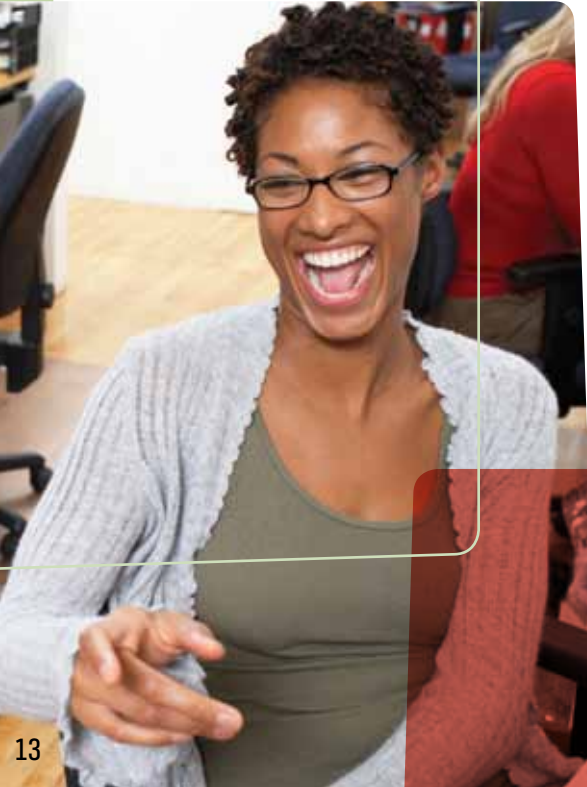
Dental Net DHMO plans

This is an overview of coverage. A comprehensive description of coverage, benefits, exclusions and limitations can be found in the Combined Evidence of Coverage and Disclosure Form.

CDT Code	Benefit	Member's copay		
		Plan 2000A	Plan 2000B	Plan 2000C
Diagnostic services				
D0120	Periodic oral examinations	\$0	\$0	\$0
D0210	Intraoral X-rays - complete series (include bitewings)	\$0	\$0	\$0
Preventive services				
D1110 or D1120	Teeth cleaning (prophylaxis) - adult or child - 2 per year	\$0	\$0	\$0
D1208	Topical fluoride, covered to age 18	\$0	\$0	\$0
D1351	Sealants, per tooth, through age 15	\$7	\$5	\$0
Restorative services, filling - permanent				
D2140	Amalgam (silver-colored) one-surface fillings	\$0	\$0	\$0
D2330	Resin-based composite (tooth-colored) fillings on anterior (front) tooth, one surface	\$0	\$0	\$0
D2391	Resin-based composite (tooth-colored) fillings on posterior (back) tooth, one surface	\$30	\$20	\$10
D2393	Resin-based composite (tooth-colored) fillings on posterior (back) tooth, three surfaces	\$55	\$45	\$30
Oral surgery services				
D7140	Simple extraction of erupted tooth or exposed root	\$15	\$5	\$5
D7210	Surgical extraction of erupted tooth	\$30	\$25	\$20
D7220	Removal of impacted tooth - soft tissue	\$50	\$45	\$40
D7230	Removal of impacted tooth - partial bony	\$70	\$60	\$50
D7240	Removal of impacted tooth - completely bony	\$100	\$70	\$60
Endodontic services				
D3220	Therapeutic pulpotomy (excluding final restoration)	\$20	\$15	\$10
D3310	Root canal: anterior (front tooth) (excluding final restoration)	\$90	\$70	\$65
D3320	Root canal: bicuspid (excluding final restoration)	\$125	\$80	\$75
D3330	Root canal: molar (excluding final restoration)	\$160	\$140	\$130
Periodontic services				
D4210	Gingivectomy: four or more contiguous teeth, per quadrant	\$95	\$70	\$55
D4211	Gingivectomy: one to three teeth touching each other (contiguous), per quadrant	\$48	\$20	\$15
D4261	Osseous surgery, one to three contiguous teeth, per quadrant	\$150	\$115	\$90
D4342	Periodontal scaling and root planning, per quadrant, one to three teeth	\$23	\$15	\$10
D4910	Periodontal maintenance	\$25	\$13	\$13
Prosthetic services				
D2750	Crown: porcelain fused to high noble metal (Example: gold)	\$175*	\$170*	\$90*
D5110 or D5120	Complete upper or lower denture	\$175	\$150	\$125
D5211 or D5212	Partial upper or lower denture, resin base (including conventional clasps, rests and teeth)	\$150	\$125	\$100
D5730, D5731, D5740 or D5741	Denture reline: chairside	\$40	\$20	\$0
D6240	Pontic (bridge), porcelain fused to high noble metal (Example: gold)	\$175*	\$150*	\$125*
Orthodontic services				
	24 months of standard orthodontic coverage, exclusive of records/retention fees			
D8080	Child (through age 17)	\$1,695	\$1,695	\$1,695
D8090	Adult	\$1,895	\$1,895	\$1,895
D8680	Retention (placement of retainers)	\$200	\$200	\$200
Other services				
	Out-of-area emergency care maximum payment \$100	All charges over \$100	All charges over \$100	All charges over \$100
D9215	Local anesthesia	\$0	\$0	\$0
D9220	General anesthesia - first 30 minutes	\$160	\$145	\$130
D9440	Office visit: after hours	\$25	\$25	\$25
D9940	Occlusal guards (mouth guards)	\$100	\$75	\$50

*Plus costs for noble or high noble metal, not to exceed \$125, and/or costs for porcelain, not to exceed \$100.

Dental Net is available in these counties: Alameda, Contra Costa, Los Angeles, Marin, Orange, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, Santa Barbara, Santa Clara, Solano and Sonoma. Dental Net has limited availability in these counties: El Dorado, Kern, Kings, Monterey, Placer, Riverside, San Mateo, Santa Cruz, Tulare and Ventura.



Get vision coverage and see increased productivity.

Comprehensive, inexpensive vision plans can play a role in managing the overall health and well-being of your employees. It's been shown that regular eye exams and wearing corrective eyewear can greatly decrease the risk of more serious, long-term eye diseases and can even result in early detection of other health conditions¹ — increasing your employees' productivity and performance. You get the picture, and so do we. That's why we've created Blue View Vision.

Blue View Vision and Blue View Vision Plus feature:

- *A broad, convenient, national network* — The Blue View Vision network has over 30,000 private practice doctors and more than 25,000 locations, including the nation's leading retail stores like LensCrafters®, Sears OpticalSM, Target Optical® and JCPenney® Optical. These retail locations offer convenient evening and weekend hours, allowing your employees to schedule appointments outside their normal work day. Although they only comprise of 6% of our network, they adjudicate 30% of our claims. Plus, 25% of eyewear is purchased on the weekends.

- *Value-added savings* — Employees enjoy additional savings of 15% to 40% on unlimited purchases of most extra pairs of eyewear, conventional contact lenses, lens treatments, specialized lenses and various accessories — even after they've exhausted their covered benefits.

They also enjoy:

- Factory scratch coating on eyeglass lenses included at no additional cost
- Transitions® and polycarbonate lenses for kids under 19 years old at no additional cost
- Transitions lenses for adults at a fixed price of \$75
- Tiered pricing for premium progressive lenses and premium anti-reflective coatings, limiting members' out-of-pocket costs

Plus, members who have our vision coverage and our ConditionCare program included in their health plan may now be enrolled in our Diabetes program if their vision claims include a diabetic-related diagnosis.

¹ American Optometric Association, aoanet.org.

Blue View Vision plans are available on an employer-paid or voluntary basis. With voluntary benefits, you can give your employees access to the additional coverage they need — and at no extra cost to you.

Vision plans

This is an overview of coverage. A comprehensive description of coverage, benefits, exclusions and limitations is contained in the Combined Evidence of Coverage and Disclosure Form.

	Blue View Vision*	Blue View Vision Plus*
Eye Exam	Every 12 months	Every 12 months
Lenses	Every 24 months	Every 12 months
Frames	Every 24 months	Every 12 months
Contact lenses	Every 24 months	Every 12 months
In-Network Copay		
Eye exam copay	\$25	\$15
In-Network Benefits		
Eye exam	Covered up to a comprehensive level exam with dilation as necessary after exam copay	
Lenses	Standard plastic lenses in single vision, bifocal or trifocal including factory scratch coating, polycarbonate lenses for kids under 19 and Transitions lenses for kids under 19; additional charge for progressive lenses	
Single vision	No copay	
Bifocal lenses		
Trifocal lenses		
Progressive lenses	\$65	
Standard		
Premium Tier 1		
Premium Tier 2		
Premium Tier 3	\$91	
Transitions lenses	\$97	
	\$103	
	\$75 for adults; no charge for children under 19	
Frames	Covered up to \$120 retail value. 20% off any balance over the allowance	
Contact lenses	Benefit allowance applies to materials; discount available on fit and follow-up	
Elective	Covered up to \$115 allowance. 15% off balance over allowance	
Conventional		
Disposable		
Non-elective**	No copay	
Additional savings	Savings available from participating providers	
Out-of-Network Reimbursement		
Eye exam	Reimbursed up to \$49	
Lenses	Reimbursed up to \$35	
Single vision		
Bifocal lenses		
Trifocal lenses		
Standard progressive lenses	Reimbursed up to \$49	
Frames	Reimbursed up to \$50	
Contact lenses	Reimbursed up to \$92	
Elective		
Conventional		
Disposable		
Non-elective**	Reimbursed up to \$250	

*Coverage for these vision PPO plans includes choice of spectacle lenses OR contact lenses, not both.

**Non-elective contacts are those prescribed for extreme visual acuity or other functional problems not treatable by spectacle lens.

Get life insurance ... and share the benefits of your employees' security.

Your employees depend on you, and their families depend on them. Life insurance is an easy, inexpensive way to help your employees 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. What's more, Anthem Blue Cross Life and Health Insurance Company is rated "A (Excellent)" for financial strength by A.M. Best Company. And we have "best in class life insurance claim payment turnaround time." Our claim turnaround time is among the fastest in the industry — usually within two days.¹

Basic term life coverage

When you offer basic term life coverage, your employees and their families will gain extra peace of mind and financial support in the event of untimely death or serious physical loss. You can select a level of basic term life coverage from \$25,000 to \$250,000. With any level of coverage, Accidental Death & Dismemberment (AD&D) benefits are included automatically.

The life benefit is payable in the event of death at any time, with the automatic AD&D feature providing employees with an additional benefit — equal to the amount of the life benefit — in case of an accidental death or a serious qualifying accident. The Living Benefit allows employees diagnosed with a 12-month life expectancy due to a terminal illness to request up to 50% of their life benefit.

Extras included with AD&D coverage

- An annual college education benefit for eligible dependents of the lesser of 25% of the AD&D coverage amount or \$12,000 if your employee should pass away while their kids are still in school
- A seat belt provision that adds the lesser of 10% of the coverage amount or \$25,000 to the AD&D benefit
- A \$5,000 maximum repatriation benefit for preparation and transportation services should death occur more than 75 miles from home

Improve member productivity and well-being with our member assistance programs

Life demands a lot, and asking for help can be difficult. That's why we automatically include Resource Advisor, a member assistance program for employees and their families. Resource Advisor provides easy access to confidential support and resources that employees and their families may need to improve their well-being and manage problems before they become an emotional or financial burden. Resource Advisor also includes identity theft victim recovery services and, through our Beneficiary Companion services, beneficiaries (executors of estate) receive assistance with important tasks required at time of death, allowing them to focus on healing.

Travel assistance — included with your group term life and accidental death and dismemberment (AD&D) insurance — gives employees and their families the comfort of knowing they are secure while traveling. When employees and their families are traveling for personal or business reasons more than 100 miles from home, they have access to emergency medical assistance, travel services and pre-departure information. All active employees with life and AD&D coverage, as well as their dependents, are eligible.

Save with composite life rates

Enroll 10 or more employees, and you'll automatically receive our composite life rates. Composite rates mean your group will receive a single rate per \$1,000 of life coverage regardless of the age or gender of those enrolling. What's in it for you? Easier administration and yet another way to get potentially lower rates.

Life coverage is easy with Guaranteed Issue amounts

All of our Anthem Blue Cross health benefits groups with two plus enrolled employees can get life coverage without going through health underwriting — and there are no health questionnaires to fill out:²

- \$30,000 maximum for two to nine enrolled employees
- \$50,000 maximum for 10 to 24 enrolled employees
- \$100,000 maximum for 25 to 50 enrolled employees

Coverage is not guaranteed for late enrollees and those enrolling in coverage that exceeds the Guaranteed Issue amount. Completed health questionnaires are required for those enrollees.

More than just a benefit check — support during a stressful time

We also provide industry-leading beneficiary support services as part of our life insurance plans. Beneficiaries receive life insurance payments in a convenient Access Advantage checking account — that gives them time to make investment decisions while also providing immediate access to funds they need.

All beneficiaries also receive grief counseling services. Beneficiaries can call our 24/7 toll-free number to get the support they need. They can also access extensive online support services. A loss can also bring legal questions and financial concerns, so we provide an extensive online legal and financial library. The Beneficiary Companion services give beneficiaries (executors of estate) assistance with important tasks like closing accounts and settling the estate, allowing them to focus on healing.



Beneficiaries can even order a copy of *The Healing Book: Facing the Death — and Celebrating the Life — of Someone You Love*. This book was written for kids and is available at no charge.

¹ LIMRA MarketScan 2011.

² Coverage is not guaranteed for late enrollees and those enrolling in coverage that exceeds the Guaranteed Issue amount. Completed health questionnaires are required for those enrollees.

Life plans

This chart provides details about basic term life and adding dependent and/or supplemental life benefits so your employees get the whole picture.

This is an overview of coverage. A comprehensive description of coverage, benefits, exclusions and limitations is contained in the Combined Evidence of Coverage and Disclosure Form.

BASIC LIFE – choose one of three options:	Benefit Amounts Available	Employer Contributions and Participation Requirements	Guaranteed Issue Guidelines
<ul style="list-style-type: none"> ◦ Schedule A: Flat dollar amounts for all employees – You select one flat dollar amount for all employees. ◦ Schedule B: Life benefits graded by job title* – You select one amount in \$1,000 increments for Class I employees (officers, managers, supervisors) and another amount for Class II employees (all others). ◦ Schedule C: Salary Based Life Insurance – You select either 1 or 2 times the employee’s annual salary. All employees must have the same salary schedule. Minimum/Maximum benefit: \$25,000/\$250,000. <p>* Job title descriptions shown are examples. You may use them as a guideline or provide your own; there must be at least one person in each class (job description). Only one benefit schedule may be offered. The benefit amount for Class I cannot exceed \$250,000 per employee and cannot exceed 2.5 times the benefit amount for Class II.</p>	\$25,000 to \$250,000	<p>If employer pays between 25% and 99%, then 75% employee participation is required.</p> <p>If employer pays 100%, then 100% employee participation is required.</p>	<p>Three levels of Guaranteed Issue are available, depending on number of enrolling employees.</p> <p>2-9 employees: \$30,000 10-24 employees: \$50,000 25-50 employees: \$100,000</p>
DEPENDENT LIFE – two levels of optional dependent life coverage are available:			
<ul style="list-style-type: none"> ◦ \$10,000 / \$1,000 Option: \$10,000 for spouse, \$10,000 for children 6 months to 26 years of age and \$1,000 for children under 6 months of age. Available only if employee life benefit is \$20,000 or more. Employee monthly rate is \$4 per family. ◦ \$5,000 / \$500 Option: \$5,000 for spouse, \$5,000 for children 6 months to 26 years of age and \$500 for children under 6 months of age. Employee monthly rate is \$2 per family. <p>AD&D benefits are not available with Dependent Life coverage.</p>	\$10,000 / \$1,000 or \$5,000 / \$500	<p>Employer is not required to contribute toward the cost of dependent life coverage.</p> <p>If employees are paying part of the premium, at least 75% of all eligible employees with dependents must participate in dependent life coverage.</p>	All amounts are Guaranteed Issue.
SUPPLEMENTAL LIFE			
<ul style="list-style-type: none"> ◦ 100% employee paid. ◦ Available in four benefit amounts: \$15,000, \$25,000, \$50,000 or \$100,000 (\$100,000 level only available to groups with 11 or more eligible employees). 	\$15,000 / \$25,000 / \$50,000 or \$100,000	<p>Premiums are 100% employee paid. Required participation depends on group size:</p> <p>2-3 employees: 100% participation 4-10 employees: 25% participation (min. three) 11-50 employees: 25% participation (min. three)</p>	\$15,000 is available for groups with 11-50 eligible employees and at least 25% participation.

Another great way to save!

In times like these, isn't it good to know Anthem Blue Cross is working hard to help your company and your employees save money on health care costs? One of the easiest and most convenient ways to save is by ordering maintenance medications through our mail-order pharmacy.

Employees can save more than 66% using mail order!

Our mail-order service pharmacy is a proven money saver. Get a 90-day mail-order supply for the same cost as a 30-day retail supply for generics!* Go with brand or brand nonformulary medications and get a 90-day supply for the same cost as a 60-day retail supply.** Mail order slashes prescription costs by giving you and your employees' greater supplies of maintenance medications for as little as one-third the cost.

	Retail Cost	Mail-Order Cost	Annual Mail-Order Savings
Annual savings for an employee on a single generic maintenance medication*	\$120	\$40	\$80!

*May not apply to certain plans .

**Only available on Lumenos HSA 3000 and Select \$25 HMO plans. Does not apply when generic equivalent medication is available.

*Comparing \$10 Copay for 30-day supply at retail vs. \$10 Copay for 90-day supply with mail order

Anthem Health and Wellness — a valuable part of every plan, all year round.

Quite simply, our Health and Wellness programs give 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 achieve optimal health outcomes, members have access to:

- Innovative tools and resources
- Health and wellness guidance
- Programs to help manage chronic conditions

Your employees will also appreciate the personalized programs that help manage and coordinate care for more than 40 chronic conditions. Anthem Health and Wellness programs 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.

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

As part of the largest health benefits company in the country, we have the experience, strength and stability to create — and stand by — solutions that work for you and your employees. We're proud to work with you now and, as your business grows, helping you keep it simple and affordable every step of the way.

Call your Anthem Blue Cross agent today. Or check out [anthem.com/ca](https://www.anthem.com/ca).



BeneFits Plan Guidelines, Exclusions and Limitations, General Provisions

Enrollment Guidelines

Eligible Employees

- **Full time:** Employees must be employed on a permanent, full-time basis and have a normal work schedule of at least 30 hours per week. In addition, they must be compensated for that work by the employer (subject to withholding appearing on a **W-2 form**).
- **Part time:** Employees must be employed on a permanent, part-time basis and be compensated for that work by the employer (subject to withholding appearing on a **W-2 form**). Minimum hours per week for eligibility is 20. The employee must have worked at least 20 hours, but not more than 29 hours, per normal work week for at least 50% of the previous calendar quarter and must have completed the probationary period selected by the employer. Additional part-time eligibility is available to part-time employees working 15 to 29 hours per week only if this option is selected by the employer. It is the employer's option to offer health coverage to part-time employees. If that option is exercised, all similarly situated individuals must be offered coverage under the employer's benefit plan.
- **Other:** Seasonal workers in select SIC code agricultural industries and private household staff may be considered eligible employees, subject to underwriting approval.
- **Sole proprietors/partners/corporate officers:** Must work at least 20 hours per week to be eligible for coverage.
- **Cal-COBRA, COBRA, FMLA-eligible groups:** For employees who are qualified for coverage under Cal-COBRA (California law **SB 719**), COBRA (the **Federal Consolidated Omnibus Budget Reconciliation Act**) or FMLA (**Family and Medical Leave Act**), the employer must complete a questionnaire, indicating the qualifying event and the date continuation coverage began.

Ineligible Employees

Temporary, leased or substitute workers and persons compensated on a 1099 basis are not eligible to enroll in an Anthem Blue Cross Small Group plan.

Eligible dependent has one of the following relationships with an eligible employee:

- Lawful spouse
- Domestic partner (restrictions apply)
- Natural child up to age 26
- Legally adopted child
- Newborn child
- Ward of legal guardian
- Child of enrolled spouse or domestic partner

Effective Date

The date coverage takes effect for a group, subject to underwriting approval, must be the first or 15th of a month.

Employer Waiting Periods

After employees are hired, there may be a specific period they must be employed, known as an employer waiting period, before they and their dependents become eligible, for group coverage. The employee's eligibility date is the first of the month after the waiting period ends. Employers may choose a waiting period of the first of the month following an employee's date of hire, or one, two, three, four, five or six months of employment before an employee becomes eligible for benefits. (Seasonal workers must have a zero month waiting period).

Spouses

A husband and wife employed at the same company may both be covered as employees. Children may be considered the dependents of one but not both of the employees.

Term of Coverage

Coverage remains in force as long as the group pays the required premium on time and remains eligible for membership. Coverage will cease if the group becomes ineligible for reasons including, but not limited to, the following:

- Failure to provide accurate eligibility information or other breach of contract
- Material misrepresentation(s)
- Nonpayment of premium
- Failure to meet minimum contribution and participation requirements

Adding Employees and Dependents

New employees and dependents must submit completed applications to Anthem Blue Cross within 30 days of becoming eligible for coverage.

Applications must be received no later than the last day of the month before the requested effective date.

Declining Coverage

Employees who choose not to participate in a group's health plan must decline coverage by completing sections 3 and 5 of the *BeneFits Employee Application* within 30 days of becoming eligible.

Late Enrollment/Open Enrollment

Employees and dependents eligible for coverage who choose to enroll at a later date may be considered late enrollees. Late enrollees who initially declined coverage are eligible to enroll on their group's anniversary date. This process is known as open enrollment.

Waiting Period for Pre-Existing Conditions

A pre-existing condition is an illness, disease or physical condition for which health advice, diagnosis, care or treatment was recommended or received from a licensed health practitioner during the six months before the effective date of coverage or the first day of the waiting period, whichever is earlier. If an employee or dependent applies for coverage within 63 days of terminating membership in an Individual health care plan, or within 180 days of terminating coverage in a group health care plan, Anthem Blue Cross will credit the time enrolled in the previous plan toward the pre-existing condition waiting period.

Out-of-State Employees

The majority of eligible employees (at least 51%) must be employed within the state of California. Out-of-state employees may not choose HMO plans.

Rate Guarantees

AB 1672-qualifying groups will receive rate guarantees of 12 months. The rating formula for the group will not change during the guarantee period. Beyond the guarantee period, Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company reserve the right to change rates, change coverage or amend the group's contract with 30 days' notice, as permitted by law. A group member's rate may be adjusted at any time because of changes in age, residence or number of dependents.

Changes in Coverage

A group may request changes in its waiting period, contribution approach, coverage, plans or benefits six months after the original effective date or once in a 12-month period. Requests for coverage changes must be received 30 days before the requested effective date, and these requests are subject to underwriting review. Certain other change requests can only become effective on the group's anniversary date and may be subject to underwriting review, including the following:

- Risk Adjustment Factor (RAF) review initiated by the employer
- Adding domestic partner coverage
- Adding part-time employee coverage

Note: A benefit modification does not initiate a new rate guarantee period.

Health Plans Exclusions & Limitations

Request a copy of the Combined Evidence of Coverage/Certificate for comprehensive details on covered services, limitations and exclusions.

Exclusions and Limitations Common to All Health 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. Routine hearing tests, except as specifically stated in the *Combined Evidence of Coverage and Disclosure Form/Certificate*.
- Sex changes.
- Dental services, except as specifically stated in the *Combined Evidence of Coverage and Disclosure Form/Certificate*.
- Orthodontic Services: Braces, other orthodontic appliances, orthodontic services, except for orthodontic services related to Reconstructive Surgery for cleft palate as specifically stated for dental-related benefits under the benefit sections of the Combined Evidence of Coverage and Disclosure Form/Certificate.
- Cosmetic surgery.
- 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 or by a public school system or district unless specifically provided or arranged by us.
- Diagnostic admissions.
- Telephone, email 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 as specifically stated in the *Combined*

- *Evidence of Coverage and Disclosure Form/Certificate* or as required by law.
- Genetic testing for nonhealth reasons or when there is no health 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). Pre-existing condition exclusion does not apply to covered persons under 19 years old.
- Educational Treatment or Services that are educational, vocational, or training in nature, except as stated in the Combined Evidence of Coverage and Disclosure Form/Certificate and/or specifically provided by Anthem Blue Cross.
- Infertility services (including sterilization reversal), 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*.
- Non-Licensed Providers : Treatment or services provided by a non-licensed health care provider and treatment or services for which a health care provider license is not required. This includes treatment or services provided by a non-licensed provider under the supervision of a licensed Physician, except as specifically provided or arranged by us.
- Vein Treatment: except as stated in the Combined Evidence of Coverage and Disclosure Form/Certificate and/or provided or arranged by us.
- Online Visits except as specifically stated under the benefit sections of this Combined Evidence of Coverage and Disclosure Form. **Note:** Not covered for HMO.

Additional Exclusions and Limitations Applicable Only to the Select HMO plan

- Care not authorized by your PMG or IPA.
- Amounts in excess of maximum allowed amount for care rendered by a nonparticipating provider without an authorized referral from your PMG or IPA.
- Commercial weight-loss programs
- Health supplies and equipment/durable medical equipment, except as specifically stated in the Combined Evidence of Coverage and Disclosure Form/Certificate.
- Rehabilitative care, such as physical therapy, occupational therapy, speech therapy and chiropractic services, unless provided by a Home Health Agency or a Visiting Nurse Association 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 the Hospital BeneFits 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.

Dental Plan Exclusions and Limitations

This is only a summary of the exclusions and limitations. Please refer to the Evidence of Coverage or Certificate for complete details on the exclusions and limitations.

Exclusions and Limitations Common to All Dental Plans:

- Any amounts in excess of the maximum amounts stated in this plan.
- Services received before your effective date or services received after your coverage ends. For individual procedures in a prescribed treatment plan, no benefits will be provided for treatment BEGUN before your effective date and/ or COMPLETED after your coverage ends.
- Services for which no charge is made to you in the absence of insurance coverage.
- Any services performed for cosmetic purposes (including but not limited to external bleaching, bleaching of non-vital discolored teeth, composite restorations, veneers, crowns on teeth not exhibiting pathology and facings on crowns on posterior teeth).
- Charges for treatment by other than a licensed dentist, except charges for dental prophylaxis performed by a licensed dental hygienist.
- Diagnosis or treatment of the joint of the jaw and/or occlusion.
- Procedures requiring restorations (other than those for replacement of structure loss from caries) that are necessary to alter, restore or maintain occlusions.
- Correction of congenital or development malformation.
- All hospital costs and any additional fees charged by the dentist for hospital treatment.
- Implants: Materials implanted into or on bone or soft tissue and all adjunctive services.
- Services or supplies that are not medically necessary.
- Replacement of existing fillings for any purpose other than restoring active decay.

Exclusions and Limitations for Dental Net ONLY:

- Replacement of an existing prosthesis which has been lost or stolen; or which in the opinion of the dentist is or can be made satisfactory.
- Treatment by a nonparticipating dentist.
- Surgical services: Tooth implantation or transplantation, orthognathic surgery, soft tissue or osseous grafts, hemisection, or root amputation, apexification, alveoplasty, vestibuloplasty, or ostectomy procedures.
- Prosthetic services age limitations: Inlays, onlays, crowns, fixed bridges, or removable cast partials for members 16 years of age.
- Space maintainers for members under 16 years of age.
- Extensive oral rehabilitation.
- Periodontal splinting: Dental treatment or expenses incurred in connection with periodontal splinting.
- General anesthesia: General anesthesia, inhalation sedation, intravenous sedation or intramuscular sedation.
- Composite resin and porcelain restorations: Porcelain or composite labial veneers for fixed prosthodontics, posterior to the second bicuspid and composite fillings posterior to the cuspid.
- Waiting period for surgical periodontics and fixed prosthodontics or individual crown restorations: A member must be enrolled for a period of six consecutive months under this *Combined Evidence of Coverage and Disclosure Form* to be eligible for benefits for services related to surgical periodontics and fixed prosthodontics or individual crown restorations.

Exclusions and Limitations for Dental Net Orthodontic

Orthodontic Limitations:

- Authorized orthodontic services only.
- Orthodontic retention phase of care – The retention services fee of \$250 is the member's responsibility and is payable at the beginning of the retention phase of treatment.
- Orthodontic consultation/observation fees – If treatment is not required or you choose not to start treatment after a diagnosis and consultation have been completed by the provider, you may be charged a consultation fee of \$30 in addition to diagnostic record fees.

Orthodontic Exclusions:

- Myofunctional therapy
- Replacement of orthodontic appliances
- Orthopaedic/orthodontic treatment
- Orthodontic treatment incidental to surgical procedures
- Surgical Procedures Incidental to orthodontic treatment
- Treatment of orthodontic cases begun prior to the member's effective date of eligibility or after the termination of eligibility for coverage.
- Changes in treatment
- T.M.J. or hormonal imbalance orthodontic services
- Orthodontic records
- Special orthodontic appliances
- The retreatment of a previously treated orthodontic case is not covered.

Specialty Pharmacy Program

Specialty medications, which are used to treat complex conditions, are usually dispensed as an injectable drug, but may be available in other forms, such as a pill or inhalant. Specialty drugs are limited to a 30-day supply for each fill.

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 health 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 health 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, then the member and Anthem Blue Cross agree to resolve any and all disputes through binding arbitration pursuant to the binding arbitration agreement that the member signs upon enrollment.

Medicare

Federal TEFRA, DEFRA and COBRA legislation has been enacted to regulate employee health care coverage. Based on this legislation and the limitations of the Anthem Blue Cross agreement, if a business employs, on average, fewer than 20 employees in a year and any employee becomes age 65, the employee's primary carrier must be Medicare. For these employees that are 65 and chose to retain their Anthem Blue Cross Small group coverage, Anthem Blue Cross will apply, and Medicare is the primary coverage, and the employer's group health plan is secondary for employees with Medicare Parts A and B, this can qualify a group for a reduced premium rate from their health plan for medical benefits for these Medicare-eligible employees. The employer will be required to supply Anthem Blue Cross with validation of small group status at each renewal to continue to qualify for the reduced rates. If an employer has any employee who becomes 65 years of age, that employee's primary health carrier must be Medicare. For these employees who are 65 years old and choose to retain their Anthem Blue Cross Small Group coverage, Anthem Blue Cross will apply contract benefits as a secondary carrier for Medicare benefits paid or payable.

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% of the covered expense.

Third-Party Liability

If a member is injured, the responsible party may be legally obligated to pay for health expenses related to that injury. Anthem Blue Cross may recover benefits paid for health 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 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 Health Care Ratio

As required by law, we are advising you that Anthem Blue Cross and its affiliated companies' incurred health care ratio for 2008 was 83.4%. 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.



Health · Pharmacy · Dental · Vision · Life

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WWW.BARRICKSINSURANCE.COM

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.

This summary of benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this summary of benefits. This summary of benefits, as updated, is subject to the approval of the California Department of Insurance and the California Department of Managed Health Care (as applicable).

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