



Individual and Family Health Care Plans for California

CORE 5000

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These amounts show your share of costs after any deductibles.



Benefit	In-Network	Out-of-Network
Annual Deductible (Combined for In-Network and Out-of-Network)	\$5,000 per member, inpatient or surgical procedures only. (Once 2 members each reach the deductible, the deductible is satisfied for the entire family.)	\$5,000 per member, inpatient or surgical procedures only. (Once 2 members each reach the deductible, the deductible is satisfied for the entire family.)
Lifetime Maximum (Combined for In-Network and Out-of-Network)	\$5,000,000 per member	\$5,000,000 per member
Annual Out-of-Pocket Maximum¹ (In addition to deductible) (Combined for In-Network and Out-of-Network)	\$2,500 per member, only hospital costs apply (Once 2 members each reach the maximum, the maximum is satisfied for the entire family.)	\$2,500 per member, only hospital costs apply (Once 2 members each reach the maximum, the maximum is satisfied for the entire family.)
Doctors' Office Visits	No office visit benefit until out-of-pocket maximum is met, then you pay \$0 of negotiated fee	No office visit benefit until out-of-pocket maximum is met, then you pay 50% of negotiated fee, plus all excess charges
Professional Services (X-ray, lab, anesthesia, surgeon, etc.)	30% of negotiated fee for inpatient or surgical procedures only. No office visit benefits until out-of-pocket maximum is met, then you pay \$0 of negotiated fee	50% of negotiated fee, plus all excess charges for covered inpatient or surgical procedures only.
Hospital Inpatient (Overnight Hospital Stays)	30% of negotiated fee ²	All charges except \$650 per day
Hospital Outpatient (If You Don't Stay Overnight)	30% of negotiated fee ²	All charges except \$380 per day
Emergency Room Services (Additional \$100 copay for each visit. Waived if admitted as inpatient.)	30% of negotiated fee	30% of customary and reasonable fees plus all excess charges
Maternity	Not covered	Not covered
Preventive Care	Routine mammogram, Pap and PSA tests ³ : 30% of negotiated fee (deductible waived) HealthyCheck SM Centers ⁴ : \$25/\$75 copay for basic/premium screening (deductible waived)	Routine mammogram, Pap and PSA tests ³ : 50% of negotiated fee plus all excess charges (deductible waived)
Chiropractic Services (Combined for In-Network and Out-of-Network)	Not covered unless during inpatient admission	Not covered unless during inpatient admission
Acupuncture/Acupressure	Not covered	Not covered
Prescription Drug Benefits (No deductible)	\$10 copay generic; (Drugs on Generic Rx Formulary only)	50% of drug limited fee schedule and all excess charges plus the copay/coinsurance as stated for in-network benefits (Drugs on Generic Rx Formulary only)

¹ Excludes non-participating charges in excess of the Anthem Blue Cross negotiated fee and non-participating charges in excess of customary and reasonable fees for emergency care. Copays/coinsurance to participating and non-participating providers apply to out-of-pocket maximum except where specifically noted in the policy.
² Additional \$500 admission charge at participating hospitals (no additional charge for preferred participating) is for inpatient stays or outpatient surgery or infusion therapy. The charge is not required for ambulatory surgical centers or medical emergencies.
³ Tests ordered by a physician are covered, including appropriate screening for breast, cervical and ovarian cancer.
⁴ One HealthyCheck visit at a HealthyCheck Center only allowed for each 12-month period. HealthyCheck applies only to adults and children age 7 and above.

What the Medical Plans Do Not Cover

Please take a few moments to review the exclusions and limitations. We want you to understand what your coverage does not include before you enroll.

These listings are an overview only. The CORE 5000 Policy/Combined Evidence of Coverage and Disclosure Form (EOC) booklets contain a comprehensive list of the plans' exclusions and limitations which you should review before you enroll. For a sample copy, ask your agent or contact Anthem Blue Cross.

Exclusions and Limitations

- Maternity or pregnancy
- Conditions covered by workers' compensation or similar law.
- Experimental or investigative services.
- Services provided by a local, state, federal or foreign government, unless you have to pay for them.
- Services or supplies not specifically listed as covered under the Policy/EOC.
- Services received before your effective date.
- Services received after coverage ends.
- Services you wouldn't have to pay for without insurance.
- Services from relatives.
- Any services received by Medicare benefits without payment of additional premium.
- Services or supplies that are not medically necessary.
- Routine physical exams, except for preventive care services (e.g., physical exams for insurance, employment, licenses or school are not covered)
- Any amounts in excess of the maximum amounts listed in the Policy/EOC.
- Sex changes.
- Cosmetic surgery.
- Services primarily for weight reduction except medically necessary treatment of morbid obesity.
- Dental care, dental implants or treatment to the teeth, except as specifically stated in the Policy/EOC.
- Hearing aids.
- Contraceptive drugs and/or certain contraceptive devices, except as specifically stated in the Policy/EOC.
- Infertility services.
- Preventive benefits, except for Pap and PSA tests, and mammograms, not specifically listed in the Policy
- Acupuncture/Acupressure
- Physician office visits and associated costs, except as specifically described in the Policy
- Physical or occupational medicine or chiropractic services, except those provided during an inpatient hospital confinement
- Private duty nursing.
- Eye exams and eyeglasses or contact lenses, except as specifically stated in the Policy/EOC.
- Vision care including certain eye surgeries to replace glasses, except as specifically stated in the Policy/EOC.
- Mental and nervous disorders and substance abuse, except as specifically stated in the Policy/EOC.
- Certain orthopedic shoes or shoe inserts, except as specifically stated in the Policy/EOC.
- Services or supplies related to a preexisting condition.
- Outdoor treatment programs.
- Telephone or facsimile machine consultations.
- Educational services except as specifically provided or arranged by Anthem Blue Cross.
- Nutritional counseling.
- Food or dietary supplements, except for formulas and special food products to prevent complications of phenylketonuria (PKU).
- Care or treatment furnished in a non-contracting hospital, except as specifically stated in the Policy/EOC.
- Personal comfort items.
- Custodial care.
- Certain genetic testing.
- Outpatient speech therapy, except as specifically stated in the Policy/EOC.
- Any amounts in excess of maximums stated in the Policy/EOC.
- Outpatient drugs, medications or other substances dispensed or administered in any outpatient setting.
- Services or supplies supplied to any person not covered under the Agreement in connection with a surrogate pregnancy.

Rights and Obligations

No-Obligation Review Period

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

Incurred Medical Care Ratio

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

Enrollment Guidelines

To enroll, you and/or your dependents must be:

- Age 64 $\frac{3}{4}$ or younger;
- A permanent legal resident of California;
- A U.S. resident for at least the last 3 months;
- The applicant's spouse or domestic partner, age 64 $\frac{3}{4}$ or younger;
- The applicant's children (under 19 years of age), or the children (under 19 years of age) of the applicant's enrolling spouse or qualified domestic partner;
- The applicant's unmarried dependent children between the ages of 19 through 22 ("dependent" as defined by the Internal Revenue Service)
- The applicant's child (of any age) who is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition and is chiefly dependent upon the applicant for support and maintenance.

Medical Underwriting Requirement

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

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

If you have a significant medical condition and do not qualify for the plan in this brochure or if you have discontinued group coverage, please contact your Anthem Blue Cross representative for information regarding other Individual coverage options.

Waiting Periods

There is a specific six-month waiting period for coverage of any condition, disease or ailment for which medical advice or treatment was recommended or received within six months preceding the effective date of coverage. If you apply for coverage within 63 days of terminating your membership with another "creditable" health care plan, then you can use your prior coverage for credit toward the six-month waiting period. Anthem Blue Cross will credit the time you were enrolled on the previous plan. Consult with your Anthem Blue Cross agent or representative if you have a question about the underwriting process.

**This brochure provides a brief summary of benefit and services.
If there is any difference between this brochure and the Policy, the Policy will prevail.**