

Summary of Plans



- ClearProtectionSM Plus
- CoreGuardSM Plus
- SmartSense[®] Plus
- Premier Plus
- PPO Share

Benefits

Calendar Year Deductible

Individual

Family

Network Coinsurance Options

Calendar Year Out-of-Pocket Maximum

Individual

Family

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

Lifetime Maximum

Covered Services

Doctors' Office Visits

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

Inpatient Services
(overnight hospital/facility stays)

Outpatient Services
(without overnight hospital/facility stays)

Emergency Room Services

Preventive Care Services

Maternity

Optional Coverage (at additional cost)

Prescription Drug Coverage

Retail Drugs (and Mail Order Drugs when available)

Optional Drug Coverage
(when available)

Other Covered Benefits include but are not limited to:

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

ClearProtectionSM Plus

ALL COVERED NETWORK AND NON-NETWORK SERVICES APPLY TOWARD THE DEDUCTIBLES BELOW*

| | | |
|--------------------------|--------------------------|---|
| \$1,000 or \$4,500 | \$3,300 or \$6,800 | For Inpatient/Surgical and Emergency Room Services or For Outpatient/Professional and Diagnostic Services |
|--------------------------|--------------------------|---|

| | | |
|--------------------------|---------------------------|---|
| \$2,000 or \$9,000 | \$6,600 or \$13,600 | For Inpatient/Surgical and Emergency Room Services or For Outpatient/Professional and Diagnostic Services |
|--------------------------|---------------------------|---|

| | | |
|-----------|-----------|---|
| 40% 0% | 40% 0% | For Inpatient/Surgical and Emergency Room Services For Outpatient/Professional and Diagnostic Services |
|-----------|-----------|---|

ALL COVERED SERVICES, IN ANY COMBINATION, APPLY TOWARD YOUR OUT-OF-POCKET MAXIMUM BELOW*
This is the maximum you'll pay for most network covered services each calendar year; then the plan pays 100%

| | | | | |
|------------|--------------------------------|---------|---------|---|
| Individual | NETWORK: or NON-NETWORK: | \$4,500 | \$6,800 | (these amounts include the deductibles) |
|------------|--------------------------------|---------|---------|---|

| | | | | |
|--------|--------------------------------|---------|----------|---|
| Family | NETWORK: or NON-NETWORK: | \$9,000 | \$13,600 | (these amounts include the deductibles) |
|--------|--------------------------------|---------|----------|---|

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

Unlimited

Your Share of Costs (after deductible, if applicable)

NETWORK: First 2 Office Visits (per member): \$40 copay, deductible waived
Additional Office Visits: 100% of negotiated fee; then 0% Coinsurance after out-of-pocket maximum is met
NON-NETWORK: 100% Coinsurance; then 50% Coinsurance after out-of-pocket maximum is met

NETWORK: Inpatient: 40% Coinsurance
Outpatient: 100% of negotiated fee; then 0% Coinsurance after out-of-pocket maximum is met
NON-NETWORK: Inpatient: 50% Coinsurance
Outpatient: 100% Coinsurance; then 50% Coinsurance after out-of-pocket maximum is met

NETWORK: 40% Coinsurance
NON-NETWORK: All charges except \$650 per day

NETWORK: Surgery: 40% Coinsurance
Other Services: 100% of negotiated fee; then 0% Coinsurance after out-of-pocket maximum is met
NON-NETWORK: All charges except \$380 per day

NETWORK: 40% Coinsurance plus \$100 Emergency Room copay (copay waived if admitted)
NON-NETWORK: 40% Coinsurance plus \$100 Emergency Room copay (copay waived if admitted)

Includes all nationally recommended preventive services including well-child care, immunizations, PSA screenings, Pap tests, mammograms and more.
NETWORK: 0% Coinsurance, not subject to deductible
NON-NETWORK: 100% Coinsurance; then 50% Coinsurance after out-of-pocket maximum is met

Not Covered

Dental, Life

ClearProtection Plus

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

Not Available

Ambulance, Home Health Care, Physical/Occupational Therapy, Urgent Care

*Network and non-network deductible are combined and accumulate toward each other. Network and non-network out-of-pocket maximums are also combined and accumulate toward each other.

NOTES: Discounted network rates apply for network covered services. For non-network services, member is responsible for the coinsurance plus charges in excess of the allowable amount. Copays/Coinsurance to network and non-network providers apply to annual out-of-pocket maximum except where specifically noted in the Policy.

ClearProtection Plus is offered by Anthem Blue Cross Life and Health Insurance Company.

Benefits

Calendar Year Deductible

| | | |
|------------|--------------|--|
| Individual | NETWORK: | |
| | NON-NETWORK: | |
| Family | NETWORK: | |
| | NON-NETWORK: | |

Network Coinsurance Options

Calendar Year Out-of-Pocket Maximum

| | | |
|------------|--------------|--|
| Individual | NETWORK: | |
| | NON-NETWORK: | |
| Family | NETWORK: | |
| | NON-NETWORK: | |

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

Lifetime Maximum

Covered Services

Doctors' Office Visits

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

Inpatient Services (overnight hospital/facility stays)

Outpatient Services (without overnight hospital/facility stays)

Emergency Room Services

Preventive Care Services

Maternity

Optional Coverage (at additional cost)

Prescription Drug Coverage

Retail Drugs (and Mail Order Drugs when available)

Optional Drug Coverage (when available)

Other Covered Benefits include but are not limited to:

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CoreGuardSM Plus

Your Choices

| | | | | | |
|------------|---------|---------|---------|---------|----------|
| | \$750 | \$1,500 | \$2,500 | \$3,500 | \$5,000 |
| Individual | \$750 | \$1,500 | \$2,500 | \$3,500 | \$5,000 |
| Family | \$1,500 | \$3,000 | \$5,000 | \$7,000 | \$10,000 |
| | \$1,500 | \$3,000 | \$5,000 | \$7,000 | \$10,000 |
| | 50% | 50% | 50% | 50% | 50% |

Add Your Chosen Deductible to the Amount Below¹

| | | | | | |
|------------|----------|----------|----------|----------|----------|
| Individual | \$3,500 | \$3,500 | \$3,500 | \$3,500 | \$3,500 |
| | \$7,500 | \$7,500 | \$7,500 | \$7,500 | \$7,500 |
| Family | \$7,000 | \$7,000 | \$7,000 | \$7,000 | \$7,000 |
| | \$15,000 | \$15,000 | \$15,000 | \$15,000 | \$15,000 |

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

Unlimited

Your Share of Costs (after deductible)

NETWORK: 50% Coinsurance
NON-NETWORK: 70% Coinsurance

NETWORK: 50% Coinsurance
NON-NETWORK: 70% Coinsurance

NETWORK: 50% Coinsurance PLUS \$500 Facility Copay¹ per day up to the first 3 days (with \$750, \$1,500, \$2,500)
50% Coinsurance (with \$3,500, \$5,000)
NON-NETWORK: 70% Coinsurance PLUS \$500 Facility Copay¹ per day up to the first 3 days (with \$750, \$1,500, \$2,500)
70% Coinsurance (with \$3,500, \$5,000)

NETWORK: 50% Coinsurance PLUS \$200 Facility Copay¹ per admission (with \$750, \$1,500, \$2,500)
50% Coinsurance (with \$3,500, \$5,000)
NON-NETWORK: 70% Coinsurance PLUS \$200 Facility Copay¹ per admission (with \$750, \$1,500, \$2,500)
70% Coinsurance (with \$3,500, \$5,000)

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

Includes all nationally recommended preventive services including well-child care, immunizations, PSA screenings, Pap tests, mammograms and more.
NETWORK: 0% Coinsurance, not subject to deductible
NON-NETWORK: 70% Coinsurance

Not Covered

Dental, Life

CoreGuard Plus

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

Not Available

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

¹ Facility Copay only applies to \$750, \$1,500 and \$2,500 deductible plans. Facility Copay does not accumulate toward the deductible or out-of-pocket maximum. Facility Copay is still required even if out-of-pocket maximum has been met. Balance of covered charges subject to deductible and coinsurance. No additional Facility Copay if readmitted to the same facility within 72 hours of the initial admission.

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

Benefits

Calendar Year Deductible

| | | | | | |
|------------|--------------|---------|---------|---------|----------|
| Individual | NETWORK: | \$1,000 | \$2,000 | \$3,500 | \$6,000 |
| | NON-NETWORK: | \$1,000 | \$2,000 | \$3,500 | \$6,000 |
| Family | NETWORK: | \$2,000 | \$4,000 | \$7,000 | \$12,000 |
| | NON-NETWORK: | \$2,000 | \$4,000 | \$7,000 | \$12,000 |

Network Coinsurance Options

| | | | |
|-----|-----|-----|-----|
| 30% | 30% | 30% | 30% |
|-----|-----|-----|-----|

Calendar Year Out-of-Pocket Maximum

| | | | | | |
|------------|--------------|----------|----------|----------|----------|
| Individual | NETWORK: | \$3,500 | \$3,500 | \$3,500 | \$3,500 |
| | NON-NETWORK: | \$7,500 | \$7,500 | \$7,500 | \$7,500 |
| Family | NETWORK: | \$7,000 | \$7,000 | \$7,000 | \$7,000 |
| | NON-NETWORK: | \$15,000 | \$15,000 | \$15,000 | \$15,000 |

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

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

Lifetime Maximum

Unlimited

Covered Services

Doctors' Office Visits

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

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

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

Inpatient Services (overnight hospital/facility stays)

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

Outpatient Services (without overnight hospital/facility stays)

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

Emergency Room Services

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

Preventive Care Services

Includes all nationally recommended preventive services including well-child care, immunizations, PSA screenings, Pap tests, mammograms and more.
NETWORK: 0% Coinsurance, not subject to deductible
NON-NETWORK: 50% Coinsurance

Maternity

Not Covered

Optional Coverage (at additional cost)

Dental, Life

Prescription Drug Coverage

Retail Drugs (and Mail Order Drugs when available)

Standard Drug Coverage:

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

Optional Drug Coverage (when available)

Upgrade Drug Coverage:

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

Other Covered Benefits include but are not limited to:

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

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

SmartSense Plus is offered by Anthem Blue Cross Life and Health Insurance Company.

Benefits

Calendar Year Deductible

| | Individual | Family |
|--------------|------------|---------|
| NETWORK: | \$1,000 | \$2,000 |
| NON-NETWORK: | \$1,000 | \$2,000 |

Network Coinsurance Options

Calendar Year Out-of-Pocket Maximum

| | Individual | Family |
|--------------|------------|----------|
| NETWORK: | \$4,500 | \$9,000 |
| NON-NETWORK: | \$7,500 | \$15,000 |

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

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

Lifetime Maximum

Unlimited

Covered Services

Doctors' Office Visits

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

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

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

Inpatient Services (overnight hospital/facility stays)

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

Outpatient Services (without overnight hospital/facility stays)

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

Emergency Room Services

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

Preventive Care Services

Includes all nationally recommended preventive services including well-child care, immunizations, PSA screenings, Pap tests, mammograms and more.

NETWORK: 0% Coinsurance, not subject to deductible
NON-NETWORK: 50% Coinsurance

Maternity

Not Covered

Optional Coverage (at additional cost)

Dental, Life

Prescription Drug Coverage

Retail Drugs (and Mail Order Drugs when available)

Tier 1 (Generic drugs): \$15 Copay

\$500 annual Prescription Drug deductible per member applies before the following:

· **Tier 2 (Formulary Brand name drugs): \$40 Copay**

· **Tier 3 (Non-Formulary Brand name drugs): \$60 Copay**

· **Specialty: 25% Coinsurance** up to a \$2,500 annual Prescription Drug out-of-pocket maximum (the most you'll have to pay), network only and in addition to \$500 annual deductible.

NON-NETWORK: Not Covered

Optional Drug Coverage (when available)

Not Applicable

Other Covered Benefits include but are not limited to:

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

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NOTES:

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

Premier Plus is offered by Anthem Blue Cross Life and Health Insurance Company.

Benefits

Calendar Year

| | | |
|-----------------------------|---------|---------|
| Individual | \$1,000 | \$5,000 |
| Network Coinsurance Options | 30% | 30% |

Calendar Year Out-of-Pocket Maximum (in addition to deductible)

| | | |
|------------|---------|---------|
| Individual | \$4,000 | \$2,500 |
|------------|---------|---------|

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

Each family member has an individual deductible. Once 2 members each reach their individual deductible, the deductible is met for the entire family. Each family member has an individual out-of-pocket maximum. Once 2 members each reach their individual out-of-pocket maximum, the maximum is met for the entire family.

Lifetime Maximum

None

Covered Services

Your Share of Costs (after deductible, unless waived)

| | | |
|--|--|--|
| Doctors' Office Visits | NETWORK: 30% Coinsurance, deductible waived NON-NETWORK: 50% Coinsurance, deductible waived | NETWORK: \$40 Copay, deductible waived NON-NETWORK: 50% Coinsurance, deductible waived |
| Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.) | NETWORK: 30% Coinsurance NON-NETWORK: 50% Coinsurance | NETWORK: 30% Coinsurance NON-NETWORK: 50% Coinsurance |
| Inpatient Services (overnight hospital/facility stays) | NETWORK: 30% Coinsurance NON-NETWORK: All charges except \$650 per day | NETWORK: 30% Coinsurance NON-NETWORK: All charges except \$650 per day |
| Outpatient Services (without overnight hospital/facility stays) | NETWORK: 30% Coinsurance NON-NETWORK: All charges except \$380 per day | NETWORK: 30% Coinsurance NON-NETWORK: All charges except \$380 per day |
| Emergency Room Services | NETWORK: 30% Coinsurance plus \$100 Emergency Room copay (copay waived if admitted) NON-NETWORK: 30% Coinsurance plus \$100 Emergency Room copay (copay waived if admitted) | NETWORK: 30% Coinsurance plus \$100 Emergency Room copay (copay waived if admitted) NON-NETWORK: 30% Coinsurance plus \$100 Emergency Room copay (copay waived if admitted) |
| Preventive Care Services | Includes all nationally recommended preventive care services, including well-child care, immunizations, PSA screenings, Pap tests, mammograms, and more. NETWORK: 0% Coinsurance, not subject to deductible NON-NETWORK: 50% Coinsurance | |
| Maternity | NETWORK: 30% Coinsurance NON-NETWORK: 50% Coinsurance | NETWORK: 30% Coinsurance NON-NETWORK: 50% Coinsurance |
| Optional Coverage (at additional cost) | Dental, Life | |

Prescription Drug Coverage

PPO Share Plan

| | | |
|--|---|---|
| Retail Drugs (and Mail Order Drugs when available) | NETWORK: Generic (Tier 1): \$15 copay Brand name (Tier 2): \$35 copay after \$250 annual brand name deductible (2 member max) NON-NETWORK: 50% of drug limited fee schedule and all excess charges plus the copay/coinsurance as stated for network benefits; subject to the \$250 annual brand name prescription drug deductible | NETWORK: Generic (Tier 1): \$15 copay Brand name (Tier 2): \$35 copay after \$750 annual brand name deductible (2 member max) NON-NETWORK: 50% of drug limited fee schedule and all excess charges plus the copay/coinsurance as stated for network benefits; subject to the \$750 annual brand name prescription drug deductible |
| Anthem Blue Cross Formulary | | |

Optional Drug Coverage

Not Available

Other Covered Benefits include but are not limited to:

Ambulance, Chiropractic Services, Home Health Care, Mental Health, Physical/Occupational Therapy, Urgent Care. (Visit limitations may apply for some of these benefits.)

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*Network and non-network deductibles are combined and accumulate toward each other. Network and non-network out-of-pocket maximums are also combined and accumulate toward each other.
NOTES:
- Discounted rates apply for network covered services.
- For non-network services, member is responsible for the coinsurance plus charges in excess of the allowable amount.
- Copays/coinsurance to network and non-network providers apply to annual out-of-pocket maximum except where specifically noted in the policy.

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

Dental Blue Basic offers:

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

Dental Blue Enhanced offers:

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

Save money by using our dental network

As a Dental Blue member, you can see *any* dentist you want; however, you do have the potential for lower costs when you choose a dentist in the Dental Blue 100 network. This is because network dentists have agreed to accept our negotiated rates for services they provide to you. If you choose to go to a provider outside of the Dental Blue 100 network, you can be billed the difference between our network negotiated rates and what your chosen dentist wishes to charge. But, with more than 19,000 California providers and provider locations in our Dental Blue 100 network, it's likely your dentist is part of our network!

Plus, network dentists have agreed to pass along our negotiated rates on covered services to you during waiting periods or if you exceed your annual maximum benefit.

Prefer a Dental HMO?

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

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

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

Dental Blue PPO is offered by Anthem Blue Cross Life and Health Insurance Company and Dental SelectHMO is offered by Anthem Blue Cross.

California Coverage Details

Things you need to know before you buy...



Premier Plus, Lumenos[®] HSA, Lumenos[®] HSA Plus, SmartSense[®] Plus, ClearProtectionSM Plus, CoreGuardSM Plus
PPO Share, Select HMO, HMO Saver, Individual HMO

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

To Enroll, You And Your Dependents Must Be:

- Age 64¾ or younger
- A permanent legal resident of California
- A U.S. resident for at least the last 3 months
- The applicant's spouse or domestic partner, age 64¾ or younger
- The applicant's children (under 26 years of age), or the children (under 26 years of age) of the applicant's enrolling spouse or qualified domestic partner
- The applicant's child (of any age) who is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition and is chiefly dependent upon the applicant for support and maintenance

Medical Underwriting Requirement

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

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

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

Incurred Medical Care Ratio

As required by law, we are advising you that Anthem Blue Cross' incurred medical care ratio for 2009 was 83.44 percent. The 2009 medical care ratio for Anthem Blue Cross Life and Health Insurance Company was 78.4 percent. These ratios were calculated after provider discounts were applied and based on regulatory rules and regulations.

Waiting Periods

For applicants age nineteen (19) and older, there is a specific six-month waiting period for coverage of any condition, disease or

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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 will credit the time you were enrolled on the previous plan. The pre-existing condition limitation does not apply to applicants under age nineteen.

Access To The Medical Information Bureau (MIB)

In accordance with federal and state privacy laws, Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company or its reinsurers may, obtain and disclose personal health information to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

You may have an MIB record if you have applied for individual insurance (life, health, disability income, long-term care or critical illness insurance) in the last seven years with a MIB Member company. You may obtain a free copy of your MIB file annually, if one exists, upon request, and subject to proper identification, by contacting MIB at 866-692-6901 (TTY 866-346-3642). If after receipt and review of your MIB file, you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act and applicable state law.

The address of MIB's Information Office is
50 Braintree Hill Park, Suite 400
Braintree, MA 02184-8734.

Information for consumers about MIB may be obtained on its website at www.mib.com.

Utilization Management and Case Management

Our Utilization Management (UM) services offer a structured program that monitors and evaluates member care and services. The UM clinical team, which is made up of health care professionals who hold active professional licenses and certificates, perform the prior authorization, concurrent and retrospective review processes explained below. The UM team follows criteria to assist in decisions regarding requests for health care and other covered benefits, and complies with specific timeframes to ensure requests are handled in a timely manner. Our case management services help you to better understand and manage your health conditions.

Prospective Review / Pre-Admission Review

Prospective review (also known as pre-service or pre-admission review) is the process of reviewing a request for a medical procedure or service before it takes place. The review occurs to ensure that: 1) the procedure is medically necessary and 2) the procedure meets your health care plan's specific guidelines prior to being performed. Requests for prospective review may include but are not limited to:

- inpatient hospitalizations
- outpatient procedures
- diagnostic procedures

- therapy services
- durable medical equipment

Prospective review is required for all elective inpatient admissions and certain outpatient services. The review process evaluates medical necessity and the best level of care and assigns expected length of stay if needed.

Concurrent Review

Concurrent review is an ongoing evaluation of a member's hospital stay, as well as ongoing extensions of services that may be needed (such as acute care facilities, skilled nursing facilities, acute rehabilitation facilities, and home health care services). The review includes physicians, member-assigned health care professionals (or member authorized representative) and takes place by telephone, electronically and/or onsite.

Concurrent review uses pre-set decision criteria in order to approve medical care (deemed to be medically necessary) and assign the right level of care for continued medical treatment. Review decisions are based on the medical information obtained at the time of the review. Concurrent review also helps to coordinate care with behavioral health programs.

Retrospective Review

The retrospective review process consists of obtaining information to determine medical necessity as it relates to services provided without approval or notice ahead of time (e.g. without pre-service notification). Relevant clinical information is required for the retrospective review process. Review decisions are based only on the medical information the doctor or other provider had at the time the member received medical care.

Case Management

Case managers are licensed healthcare professionals who work with you to help you understand your benefits and support your health care needs. The case manager works with you and your doctor to help you better understand and manage your health conditions.

What Individual Health Care Plans Do Not Cover

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

Medical Exclusions And Limitations

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

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

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

- Care not authorized by your Primary Medical Group or Independent Practice Association
- Amounts in excess of customary and reasonable charges for care rendered by a non-participating provider without a referral from your PMG or IPA

- Chiropractic services
- Immunizations for foreign travel
- Treatment for chronic alcoholism or other substance abuse except as specifically stated in the Evidence of Coverage
- Inpatient mental care, including acute alcoholism and drug addiction benefits, except detoxification
- Treatment of mental and nervous disorders, except as specifically stated in the Evidence of Coverage
- Rehabilitative care specifically stated in the Evidence of Coverage
- Reconstructive surgery, purchase or replacement of artificial limbs or prosthesis except as specifically stated in the Evidence of Coverage
- Medical, surgical and/or psychological treatment of a sexual dysfunction, except when a sexual dysfunction is a result of a physical abnormality, defect or disease
- Medical, surgical services, supplies or treatment to the joint of the jaw (temporomandibular joint), upper jaw (maxilla) or lower jaw (mandible), unless related to a tumor or accident occurring while covered
- Routine physical examinations or tests that do not directly treat an acute illness, injury or condition unless authorized by your Primary Care Physician, except in no event will any physical examination or test required by employment or government authority, or at the request of a third party, such as a school, camp or sports-affiliated organization, be covered unless medically necessary
- Care or treatment of a pregnancy, or any condition related to pregnancy (except treatment of complications of pregnancy or Cesarean-section deliveries) when conception has occurred before the effective date of the plan agreement. However, if you were covered under Creditable Coverage within 63 days of becoming pregnant, the time spent under Creditable Coverage will be used to satisfy, or partially satisfy, the six (6) month period
- Restorations: Limited to once per surface per tooth every 24 months
- Periodontal Scaling: Limited to once per quadrant every 24 months
- Periodontal Surgery: Limited to one time per quadrant in a 36-month period
- Root Canal Therapy: Limited to one treatment per tooth for initial treatment and one retreatment per tooth – for permanent teeth only
- Stainless Steel Crowns: Limited to baby teeth only. Once per tooth in any five years
- Crowns: Limited to once per tooth in any five years
- Removable, Partial and Complete Dentures: Limited to once in five years. Benefits are payable for either complete or immediate dentures, but not both
- General Anesthesia: Covered only when used in conjunction with covered oral surgical procedures

Exclusions

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

- Prescribed drugs, pre-medication or analgesia including charges for nitrous oxide or any similar local anesthetic when the charge is made separately
- Occlusal guards
- Bleaching of non-vital discolored teeth
- Crown buildups on the same tooth as an amalgam or composite restoration that was done within the same calendar year
- Procedures to alter, restore or maintain occlusion, change vertical dimension, and replace or stabilize tooth structure lost by attrition, abrasion, erosion or bruxism
- Harmful habit appliances
- Services related to diagnosis or treatment related to the temporomandibular joint (TMJ)
- Dental implants and all adjunctive services performed in conjunction with the placement or removal of implants including but not limited to surgery, cleanings, maintenance and prosthetics placed on implants
- Infection control procedures, if billed separately
- Precision attachments
- Prefabricated resin crown or stainless steel crown with resin window
- Pulpotomy on permanent teeth
- Replacement of a prosthodontic appliance (fixed or removable) more often than once in any five-year period, whether under this contract or under any prior dental coverage
- Root canal therapy on baby teeth
- Sealants on restored teeth (occlusal surface)
- Temporary/interim prosthodontia or appliances (temporary crowns, bridges, partials, dentures, etc.)
- Biopsies
- Services or supplies not specifically listed in the covered services section of the Individual Dental Plan Contract

Dental Blue® PPO Limitations And Exclusions

Limitations

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

- Oral Evaluations: Limited to two per calendar year
- Routine Cleaning or Periodontal Cleaning: Limited to two treatments per calendar year
- Fluoride: Fluoride treatment limited to two per calendar year for children up to age 19
- X-rays: Limited to one set of full-mouth X-rays or its equivalent in a five-year period
- Periapical X-rays: Limited to four films per year
- Bitewing X-rays: Limited to one set of up to four films twice per calendar year
- Sealants: Limited to children under 16 years of age for permanent unrestored first and second molars
- Treatment is limited to one application per tooth per lifetime
- Space Maintainers: Limited to once per quadrant per lifetime for children up to age 16. Includes all adjustments within six months of placement

Dental SelectHMO Limitations And Exclusions

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

- Experimental or investigative care or therapy
- Any condition for which benefits of any nature are recovered or found to be recoverable, whether by adjudication, settlement or otherwise, under any workers' compensation or occupational disease law, even if you do not claim these benefits. If there is a dispute or substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers' compensation, Anthem Blue Cross Life and Health Insurance Company will provide the plan benefits for such conditions subject to its right of recovery and reimbursement under California Labor Code Section 4903
- Any services for which you are entitled to receive Medicare benefits, whether or not Medicare benefits are actually paid
- Any services provided by a local, state, county or federal government agency, including any foreign government, except when payment under the plan is expressly required by federal or state law
- Services or supplies for which no charge is made, or for which no charge would be made if you had no insurance coverage, or services for which you are not legally obligated to pay
- Services received before your effective date or during an inpatient stay that began before your effective date
- Services rendered before coverage begins or after coverage ends
- Prescribed drugs, pre-medication or analgesia (including nitrous oxide)
- No benefits are provided for hospital or associated physician charges for any dental treatment that cannot be performed in the dentist's office because of your general health, mental, emotional, behavioral or physical limitations
- Unless an exception is specifically authorized by Anthem Blue Cross in writing, dental services must be received from your participating dentist or participating specialty dentist
- A dental treatment plan, which in the opinion of the participating dentist and/or Anthem Blue Cross is not dentally necessary for dental health or will not produce beneficial results
- Conditions caused by the inadvertent release of nuclear energy when government funds are available for treatment of illness or injury arising from such release of nuclear energy
- Treatment of fractures or dislocations
- Any treatment to correct a dental condition that resulted from dental services performed by a non-participating dentist while coverage is in effect and any dental services started by a non-participating dentist will not be the responsibility of the participating dentist or Anthem Blue Cross for completion
- Histopathological exams and/or the removal of tumors, cysts, neoplasms and foreign bodies not covered under the medical plan
- Teeth with questionable, guarded or poor prognosis are not covered for endodontic treatment, periodontal surgery or crown and bridge. Plan will allow for observation or extraction and prosthetic replacement
- Services received after the benefit limit under this agreement is reached
- Orthodontic services must be received from a participating orthodontist. In the event of loss of coverage for any reason, and at the time of loss of coverage you are still receiving orthodontic treatment, you will be responsible for the remainder of the cost for that treatment
- Replacement of lost or stolen orthodontic appliances or repair of orthodontic appliances that were broken due to negligence
- Myofunctional therapy and related services
- Surgical procedures incidental to orthodontic treatment, including but not limited to extraction of teeth solely for orthodontic reasons, exposure of impacted teeth, correction of micrognathia or macrognathia, or repair of cleft palate
- Changes in treatment necessitated by an accident of any kind
- Treatment related to the joint of the jaw (temporomandibular joint, TMJ) and/or hormonal imbalance

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

This summary of benefits provided in the enclosed brochure complies 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 the summary of benefits in the brochure.

Selecting health coverage is an important decision.

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

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

Ready to enroll?

Call your Anthem Blue Cross agent today!

Additional information

“No Obligation” review period.

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

Save time with automatic premium payment.

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

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

This summary of benefits complies 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.