Our plans fit your plans.
What makes Anthem Blue Cross plans a smart choice?

1. **A choice of plans to fit your budget.** No matter where you are in life, we have a plan that will fit your health care needs, as well as your budget.

2. **Large California network.** Our HMO network has more than 30,000 HMO doctors and 375 hospitals throughout the state. So, chances are that your doctor is one of ours. As a lower priced option, we also offer an exclusive network with nearly 17,000 SelectHMO doctors and more than 350 hospitals in 22 counties.

3. **Coverage that travels with you.** No matter where life takes you — whether it's around the state or across the country — Anthem Blue Cross has you covered for emergencies and urgent care.

4. **Dental and life insurance.** To enhance your health and financial future, we also offer dental and term life coverage.

5. **Peace of mind.** You can relax knowing that we have been providing health care coverage and security to Californians for more than 70 years. We’re committed to simplifying your life and improving your health.

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**What's an HMO plan?**

With an HMO (Health Maintenance Organization) health care plan, you'll choose a Primary Care Physician (PCP) from our HMO network. Your PCP will probably be the doctor you see the most—for routine visits and care. Your PCP will also coordinate any other health care services you may need. And if you need to see a specialist, your PCP will need to make a referral.

HMO plans are also simple to use. Features like set copays for doctor visits help make your out-of-pocket costs more predictable. And maternity benefits make these plans ideal for growing families.

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**Is your doctor in our network?**

Go to anthem.com/ca > “Find a Doctor.”
## Plan highlights

<table>
<thead>
<tr>
<th>SelectHMO</th>
<th>HMO Saver</th>
<th>Individual HMO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Our lowest priced HMO with an exclusive HMO network.</strong></td>
<td><strong>A mid-priced HMO that includes access to our entire HMO network.</strong></td>
<td><strong>Our richest HMO with no medical deductible and access to our entire HMO network.</strong></td>
</tr>
<tr>
<td><strong>Features:</strong></td>
<td><strong>Features:</strong></td>
<td><strong>Features:</strong></td>
</tr>
<tr>
<td>· Comprehensive coverage with lower monthly premiums</td>
<td>· Comprehensive coverage</td>
<td>· Comprehensive coverage</td>
</tr>
<tr>
<td>· Immediate, no-deductible benefits</td>
<td>· Immediate benefits (deductible waived) for doctors’ office visits and preventive care</td>
<td>· Immediate, no-deductible benefits</td>
</tr>
<tr>
<td>· Maternity benefits</td>
<td>· $1,500 medical deductible for hospital and emergency services helps keep premiums lower</td>
<td>· Maternity benefits</td>
</tr>
<tr>
<td><strong>You should know:</strong></td>
<td><strong>You should know:</strong></td>
<td><strong>You should know:</strong></td>
</tr>
<tr>
<td>· Exclusive HMO network includes nearly 17,000 doctors in 22 California counties</td>
<td>· Includes access to our entire HMO network of more than 30,000 doctors</td>
<td>· Includes access to our entire HMO network of more than 30,000 doctors</td>
</tr>
<tr>
<td>· If the SelectHMO network doesn’t include your doctor or is not available in your area, ask your agent about our other plans that feature larger networks</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Prescription drug coverage included

The cost of prescription drugs can be staggering and is one of the leading causes of rising health care costs. To help control your share of the costs, all our HMO plans include prescription drug coverage for both generic and brand-name drugs.

Even when you select a plan that covers both generics and brand-name drugs, it’s still a good idea to consider using generic drugs for the best value. Generic drugs have the same active ingredients as their brand-name equivalents, but normally cost less.
## Plan Benefits

<table>
<thead>
<tr>
<th>Plan Benefits</th>
<th>SelectHMO</th>
<th>HMO Saver</th>
<th>Individual HMO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In-Select Network</strong>&lt;sup&gt;1&lt;/sup&gt;</td>
<td>In-Select Network</td>
<td>In-Network</td>
<td>In-Network</td>
</tr>
<tr>
<td><strong>Annual Deductible</strong></td>
<td>$0</td>
<td>$1,500 per member</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Annual Out-Of-Pocket Limit</strong>&lt;br&gt;<em>(in addition to deductible, if any)</em></td>
<td>Individual: $3,000 per member</td>
<td>$1,500 per member</td>
<td>$3,000 per member</td>
</tr>
<tr>
<td></td>
<td>Family: Each family member has an individual out-of-pocket limit. Once 2 members each reach the limit, the limit is satisfied for the entire family.</td>
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</tr>
<tr>
<td><strong>Lifetime Maximum</strong>&lt;br&gt;<em>(the plan will pay up to this amount)</em></td>
<td>unlimited</td>
<td>unlimited</td>
<td>unlimited</td>
</tr>
<tr>
<td><strong>Covered Services</strong>&lt;br&gt;The amounts shown are your share of costs after any deductible</td>
<td>In-Select Network&lt;sup&gt;1&lt;/sup&gt;</td>
<td>In-Network</td>
<td>In-Network</td>
</tr>
<tr>
<td><strong>Doctors’ Office Visits</strong></td>
<td>$25 copay</td>
<td>$10 copay</td>
<td>$10 copay</td>
</tr>
<tr>
<td><strong>Professional Services</strong>&lt;br&gt;<em>(x-ray, lab, anesthesia, surgeon, etc.)</em></td>
<td>No charge for office visit-related services</td>
<td>No charge for office visit-related services</td>
<td>No charge for office visit-related services</td>
</tr>
<tr>
<td><strong>Hospital Inpatient</strong>&lt;br&gt;<em>(overnight hospital stays)</em></td>
<td>$250 copay per day up to the first four days, then 0% of negotiated fee per admission</td>
<td>20% of negotiated fee (after deductible)</td>
<td>20% of negotiated fee</td>
</tr>
</tbody>
</table>
### Plan Benefits

#### Select HMO
- **Annual Deductible:** $0
- **Annual Out-of-Pocket Limit:** $1,500 per member
- **Lifetime Maximum:** Unlimited

#### In-Select Network
- **Doctors’ Office Visits:** $25 copay
- **Professional Services (x-ray, lab, anesthesia, surgeon, etc.):** No charge
- **Hospital Inpatient:** $250 copay per day up to the first four days, then 0% of negotiated fee per admission
- **Hospital Outpatient:** 20% of negotiated fee
- **Emergency Room Services:** 20% of negotiated fee
- **Maternity:** Office Visits: $25 copay
  - Hospital Inpatient: $250 copay per day up to the first four days, then 0% of negotiated fee per admission
- **Preventive Care:** $25 copay for specific health maintenance services
- **Ambulance:** $50 copay (waived if admitted to hospital)
- **Chiropractic Services:** Inpatient: $0
  - Outpatient: $25 copay per visit
- **Prescription Drug Benefits:**
  - **Generic:** $10 copay
  - **Brand-name:** $30 copay after $250 Brand-name prescription drug deductible (2 member maximum)

#### In-Network
- **Doctors’ Office Visits:** $10 copay
- **Professional Services (x-ray, lab, anesthesia, surgeon, etc.):** No charge
- **Hospital Inpatient:** 20% of negotiated fee
- **Hospital Outpatient:** 20% of negotiated fee
- **Emergency Room Services:** 20% of negotiated fee
- **Maternity:** Office Visits: $10 copay
  - Hospital Inpatient: No charge
  - Outpatient: 20% of negotiated fee
- **Preventive Care:** $10 copay for specific health maintenance services
- **Ambulance:** $50 copay (waived if admitted to hospital)
- **Chiropractic Services:** Inpatient: $0
  - Outpatient: 20% of negotiated fee
- **Prescription Drug Benefits:**
  - **Generic:** $10 copay
  - **Brand-name:** $30 copay after $250 Brand-name prescription drug deductible (2 member maximum)

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1. The SelectHMO uses a smaller network of doctors and hospitals than the HMO Saver and Individual HMO.
2. The brand-name drug deductible does not apply to the out-of-pocket limit.

Note: In order to receive HMO benefits, you must choose a provider within a 30-mile radius of your home or work. The HMO plans do not cover services by non-participating providers except for emergency services and prescription drugs.
Why dental coverage?

Dental care can play an important role in your overall health. Regular checkups and cleanings can help detect the early signs of oral health problems, reduce the risk of permanent damage to your teeth and gums, and prevent costly treatments down the road.

**Dental Blue® PPO Plans feature:**
- One of the largest Dental PPO networks in the state (more than 21,000 dental locations)
- No deductibles for cleanings, exams and x-rays
- Savings on popular services like veneers, dental implants and braces
- Negotiated discounts on services during any waiting periods and after you reach your annual maximum

The Dental Blue PPO plans give you the flexibility to see any dentist, although your costs will usually be less when you see a dentist in the network.

**Dental SelectHMO Plans feature:**
- A network of more than 4,800 dentists to choose from
- No deductibles and a low $5 copay for exams, cleanings and x-rays
- Coverage for orthodontic services
- No annual maximums and no waiting periods for most services

The Dental SelectHMO network is not available in all counties so ask your agent for more details.

Why term life insurance?

Losing a loved one is hard enough without having to worry about financial obligations. Families are often unprepared for this sudden loss, and term life insurance can provide financial support and peace of mind at a difficult time.

Here are just a couple of reasons why you’ll want to purchase term life insurance from Anthem Blue Cross Life and Health Insurance Company:
- It’s inexpensive – just pennies a day
- It’s easy – no additional forms are required to enroll

### Term life monthly rates

<table>
<thead>
<tr>
<th>Age</th>
<th>$15,000 Benefit</th>
<th>$30,000 Benefit</th>
<th>$50,000 Benefit</th>
<th>$75,000 Benefit</th>
<th>$100,000 Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-18</td>
<td>$1.50</td>
<td>$3.00</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>19-29</td>
<td>$2.80</td>
<td>$5.60</td>
<td>$9.30</td>
<td>$11.25</td>
<td>$13.00</td>
</tr>
<tr>
<td>30-39</td>
<td>$3.25</td>
<td>$6.50</td>
<td>$10.80</td>
<td>$13.50</td>
<td>$16.00</td>
</tr>
<tr>
<td>40-49</td>
<td>$7.50</td>
<td>$15.00</td>
<td>$25.00</td>
<td>$33.75</td>
<td>$42.00</td>
</tr>
<tr>
<td>50-59</td>
<td>$20.90</td>
<td>$41.80</td>
<td>$69.60</td>
<td>$97.50</td>
<td>$125.00</td>
</tr>
<tr>
<td>60-64</td>
<td>$29.40</td>
<td>$58.80</td>
<td>$98.00</td>
<td>$142.50</td>
<td>$185.00</td>
</tr>
</tbody>
</table>

For more information on our dental plans or life insurance, ask your Anthem Blue Cross agent today!
What the HMO plans do not cover

The following Exclusions and Limitations will help you understand what your health care plan does not include before you enroll. These listings are an overview only. For a comprehensive list of the plans’ exclusions and limitations, you can request a copy of a Policy/Combined Evidence of Coverage and Disclosure Form (EOC) booklet. Just ask your agent or contact Anthem Blue Cross.

Exclusions and Limitations

- 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.
- Conditions covered by workers’ compensation or similar law.
- Experimental or investigational 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 plan agreement.
- 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 beneficiaries 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) as specifically stated in the Evidence of Coverage and Disclosure Form/Certificate.
- Any amounts in excess of the maximum amounts listed in the Evidence of Coverage and Disclosure Form/Certificate.
- Eyeglasses or contact lenses, except as specifically stated in the Evidence of Coverage and Disclosure Form/Certificate.
- Vision care including certain eye surgeries to replace glasses, except as specifically stated in the Evidence of Coverage and Disclosure Form/Certificate.
- Dental care, dental implants or treatment to the teeth, except as specifically stated in the Evidence of Coverage and Disclosure Form/Certificate.
- Hearing aids.
- Contraceptive drugs and/or certain contraceptive devices, except as specifically stated in the Evidence of Coverage and Disclosure Form/Certificate.
- Infertility services.
- Private duty nursing.
- 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 covered, the time spent under Creditable Coverage will be used to satisfy, or partially satisfy, the six (6) month period

Incurred medical care ratio

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

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.
To enroll, you and your dependents must be:

- Age 64 ¾ 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 ¾ 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 your 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 you’ve chosen from this brochure or if you have discontinued group coverage, please contact your Anthem Blue Cross representative for information regarding other Individual coverage options.

No-obligation review period

After you enroll in a plan offered by Anthem Blue Cross, 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.