



# How to request changes

For Groups that offer a Single Plan, Designated Plans or Mix-n-Match option  
**Please note:** Grid is based upon a combination of both benefit and premium design

**U** - Underwriting is required

**GI** - No underwriting is required if replacing existing plan with new plan

Please check the box that describes the change your group would like to make and follow the corresponding instructions.

For groups that offer All Plans or the EmployeeChoice program: You automatically have access to All Plans options, so no group level change is needed.

**We would like to:**

- Add** one or more plans. **See Guideline below.**
- Replace** one or more of our current options with an option that requires underwriting (U). **See Guideline below.**
- Replace** one or more of our current options with an option that does not require underwriting (GI). Just send a letter from the group (signed by an owner or officer) requesting the change.

**Important Note:** All employees whose plan is replaced will be moved to the new plan selection.

**Guideline** - Send the following:

1. Employer application
2. Letter from the group (signed by an owner or officer) requesting the change
3. A reconciled California Quarterly Wage and Withholding Report. (DE-6)
4. Medical Plan Change Request form, if applicable. (If ALL employees are moving to a replacement plan, the Medical Plan Change Request form is not necessary.)

**Important note:** This benefit change request will be medically underwritten and can be declined.

Use the Employer Plan Change Guide to determine if underwriting is required for groups that offer a Single Plan, Designated Plans or Mix-n-Match option. The chart uses the following symbols:

**U** - Underwriting is required

**GI** - No underwriting is required if replacing existing plan with new plan

**Mail or FAX all requests and forms to:**

Anthem Blue Cross, P.O. Box 9042,  
 Oxnard, CA 93031-9042 FAX: 805-713-7024

Submit requests during your group's open window period. Anthem Blue Cross will determine the effective date of the approved changes.

\* offered by Anthem Blue Cross

\*\* offered by Anthem Blue Cross Life & Health Insurance Company  
 Notes: The Power SelectHMO cannot be offered alongside any other HMO products; moving to a less expensive plan may mean having lesser coverage; high-deductible health plans are HSA-Compatible.

## Employer Plan Change Guide

		Premier PPO		HMO			PPO Copay					Lumenos			HSA Compatible		Power HealthFund PPO		HDHP	PPO		
		Premier \$10 Copay	Premier \$20 Copay	HMO 100%	Classic HMO	Saver HMO	Power SelectHMO	Advantage \$25 Copay	\$30 Copay	\$35 Copay GenRx	\$40 Copay	\$45 Copay GenRx	HSA Comp 1500	HSA Comp 3000	HIA Plus 3000	PPO 2400 (HSA-Comp)	PPO 3500 (HSA-Comp)	Power HealthFund 750	Power HealthFund 500	High Deductible EPO	Saver PPO	Basic PPO
<b>Move To:</b>																						
<b>Move From:</b>																						
<b>Premier PPO</b>	Premier \$10 Copay *		GI	U	GI	GI	GI	GI	GI	GI	GI	GI	U	U	U	GI	GI	GI	GI	GI	GI	GI
	Premier \$20 Copay *	U		U	GI	GI	GI	GI	GI	GI	GI	GI	U	U	U	GI	GI	GI	GI	GI	GI	GI
<b>HMO</b>	HMO 100% *	U	U		GI	GI	GI	GI	GI	GI	GI	U	U	U	GI	GI	GI	GI	GI	GI	GI	GI
	Classic HMO *	U	U	U		GI	GI	GI	GI	GI	GI	U	U	U	GI	GI	U	U	GI	GI	GI	GI
	Saver HMO *	U	U	U	U		GI	GI	GI	GI	GI	U	U	U	GI	GI	U	U	GI	GI	GI	GI
	Power Select HMO *	U	U	U	U	U		U	U	GI	U	GI	U	U	U	GI	GI	U	U	GI	GI	GI
<b>PPO Copay</b>	Advantage \$25 Copay **	U	U	U	U	U	GI		GI	GI	GI	U	U	U	GI	GI	GI	GI	GI	GI	GI	GI
	\$30 Copay *	U	U	U	U	U	GI	U		GI	GI	U	U	U	GI	GI	GI	GI	GI	GI	GI	GI
	\$35 Copay GenRx **	U	U	U	U	U	U	U	U		U	GI	U	U	U	GI	GI	U	U	GI	GI	GI
	\$40 Copay *	U	U	U	U	U	GI	U	U	GI		GI	U	U	U	GI	GI	GI	GI	GI	GI	GI
	\$45 Copay GenRx **	U	U	U	U	U	U	U	U	U	U		U	U	U	GI	GI	U	U	GI	GI	GI
<b>Lumenos</b>	HSA Comp 1500**	U	U	U	U	U	U	U	U	GI	U	GI		GI	U	GI	GI	U	U	GI	GI	GI
	HSA Comp 3000**	U	U	U	U	U	U	U	U	U	U	U	U		U	GI	GI	U	U	GI	GI	GI
	HIA Plus 3000**	U	U	U	U	U	GI	U	U	GI	GI	GI	U	U		GI	GI	U	U	GI	GI	GI
<b>HSA Compatible</b>	PPO 2400 (HSA-Comp) **	U	U	U	U	U	U	U	U	U	U	U	U	U	U		GI	U	U	GI	GI	GI
	PPO 3500 (HSA-Comp) **	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U		U	U	GI	GI	GI
<b>Power HealthFund PPO</b>	Power HealthFund 750 **	U	U	U	GI	GI	GI	U	U	GI	GI	GI	U	U	U	GI	GI		GI	GI	GI	GI
	Power HealthFund 500 **	U	U	U	GI	GI	GI	U	U	GI	GI	GI	U	U	U	GI	GI	U		GI	GI	GI
<b>HDHP</b>	High Deductible EPO*	U	U	U	U	U	GI	U	U	GI	GI	GI	U	U	U	GI	GI	GI	U		GI	GI
<b>PPO</b>	Saver PPO **	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U		GI
	Basic PPO **	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	U	

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All Small Group HMO Medical plans, High Deductible EPO plan, Premier \$10/\$20 Copay plans and PPO \$30/\$40 Copay plans are offered by Anthem Blue Cross. All other Small Group Medical plans are offered by Anthem Blue Cross Life & Health Insurance Company. Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensees of the Blue Cross Association. ANTHEM and LUMENOS are registered trademarks. The Blue Cross name and symbol are registered service marks of the Blue Cross Association. A COMPREHENSIVE DESCRIPTION OF COVERAGE, BENEFITS, EXCLUSIONS AND LIMITATIONS IS CONTAINED IN THE CERTIFICATES AND/OR COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORMS.



# Option: Your employees may want to make changes within EmployeeElect

If your needs have changed in the past year, your employees may have the opportunity to change plans if they need more coverage or more affordable options. Here's a high-level comparison of the plans available. Please note that Underwriting approval may be required. Talk with your agent about requesting a benefit modification.

## KEY BENEFITS (member in-network costs shown here)

PLANS	Annual Deductible	Annual Out-of-Pocket Maximum	Office Visits	Prescription Drugs	Inpatient Hospital Charges	RELATIVE PRICE \$ ———> \$\$\$
<b>Affordable Protection</b> Our most affordable PPOs provide solid protection at budget-friendly prices.	Basic PPO**	\$1,250	Deductible + \$2,000	Not covered	\$10 generic/\$25 brand-name	20% after deductible
	Saver PPO**	\$500	\$2,000	Limited coverage	\$10 generic/\$25 brand-name	20% after deductible
	PPO \$45 Copay GenRx**	\$750	\$4,500	\$45/first 12; then 45%	Generic only: \$15 (Anthem Blue Cross-negotiated savings on in-network brand-name drugs)	45% after deductible
	PPO \$35 Copay GenRx**	\$500	\$4,000	\$35/first 12; then 45%	Generic only: \$15 (Anthem Blue Cross-negotiated savings on in-network brand-name drugs)	35% after deductible
<b>Dollars &amp; Sense</b> These HSA-compatible PPO plans offer comprehensive health coverage and a savvy financial strategy all in one.	PPO 3500 (HSA-compatible)**	\$3,500 (medical/pharmacy combined)	\$4,000 (medical/pharmacy combined)	\$35 after deductible	\$10 generic/\$25 brand-name after annual deductible	0% after deductible
	PPO 2400 (HSA-compatible)**	\$2,400 (medical/pharmacy combined)	\$3,600 (medical/pharmacy combined)	\$35 after deductible	\$10 generic/\$25 brand-name after annual deductible	20% after deductible
	Lumenos HSA 3000** (HSA-compatible)	\$3,000 (medical/pharmacy combined)	\$3,000 (medical/pharmacy combined)	0% after deductible Deductible waived for nationally recommended preventive care services.	0% after annual deductible	0% after deductible
	High Deductible EPO*	\$2,000 (medical/pharmacy combined)	\$3,100 (medical/pharmacy combined)	20% after deductible	\$10 generic/\$25 brand-name after annual deductible	20% after deductible
	Lumenos HSA 1500** (HSA-compatible)	\$1,500 (medical/pharmacy combined)	\$1,500 (medical/pharmacy combined)	0% after deductible Deductible waived for nationally recommended preventive care services.	0% after annual deductible	0% after deductible
<b>First Things First</b> These plans give you first-dollar coverage for many of the services you need most.	Power HealthFund 500**	First plan pays \$500; then member pays \$1,000 deductible	\$5,000	\$40 after first dollar coverage and deductible	\$10 generic/\$35 brand-name after \$350 brand-name deductible	40% after first dollar coverage and deductible
	Power HealthFund 750**	First plan pays \$750; then member pays \$500 deductible	\$5,000	\$35 after first dollar coverage and deductible	\$10 generic/\$30 brand-name after \$250 brand-name deductible	25% after first dollar coverage and deductible
	Lumenos HIA Plus 3000**	Health Incentive Plan allocation \$1,000 single member (applies to deductible) Annual deductible \$3,000 single member (medical/pharmacy combined) <sup>1</sup>	\$3,000 (medical/ pharmacy combined)	0% after deductible Deductible waived for nationally recommended preventive care services.	0% after annual deductible	0% after deductible
<b>Ideal Balance</b> Looking for an ideal mid-range cost and comprehensive benefit balance? Take a look.	PPO \$40 Copay*	\$500	\$4,500	\$40/first 12; then 45%	\$15 generic/\$25 brand-name after \$150 brand-name deductible	40% after deductible
	PPO \$30 Copay*	\$500	\$4,000	\$30/first 12; then 45%	\$15 generic/\$25 brand-name after \$150 brand-name deductible	30% after deductible
	Advantage PPO \$25 Copay**	\$250	\$3,600	\$25/first 12; then 45% up to \$900; then 10% up to \$3,600	\$15 generic/\$25 brand-name	30% up to \$900, then 10% up to \$3,600 after deductible
<b>Simple &amp; Consistent</b> HMO plans are great if you want to simplify decision-making and pay predictable costs.	Power SelectHMO*	\$500	\$2,250	\$25/primary care physician; \$35/specialist referral	\$15 generic/\$25 brand-name after \$150 brand-name deductible	10% after deductible
	Saver HMO*	\$1,500	\$2,250	\$20	\$10 generic/\$25 brand-name after \$150 brand-name deductible	No charge after deductible
	Classic HMO*	None	\$1,750	\$20	\$10 generic/\$25 brand-name after \$150 brand-name deductible	\$250 copay per admission
	HMO 100%*	None	\$1,750	\$10	\$10 generic/\$20 brand-name after \$150 brand-name deductible	No charge
<b>Superior Designs</b> These top-of-the-line PPO plans have rich benefits and low deductibles.	Premier PPO \$20 Copay*	\$250	\$3,000	\$20/first 12; then 40%	\$15 generic/\$25 brand-name	20% after deductible
	Premier PPO \$10 Copay*	\$250	\$2,500	\$10/first 12; then 30%	\$10 generic/\$20 brand-name	10% after deductible

Relative price illustrations are based on the average Standard Employer Risk Rates for each plan. Please request a quotation for actual rates, which will vary according to geographic area and the group's risk profile.

**Important:** These charts are designed to help begin the selection process; they do not provide adequate information to make a final decision. Benefits listed are per-member in-network costs, subject to deductible and copayments unless otherwise stated, for initial comparison purposes only. Do not submit an application until you review each plan's Summary of Features brochure and the Sales and Enrollment Guide. All Small Group HMO Medical plans, High Deductible EPO plan, Premier \$10/\$20 Copay plans and PPO \$30/\$40 Copay plans are offered by Anthem Blue Cross. All other Small Group Medical, Term Life and AD&D products are offered by Anthem Blue Cross Life & Health Insurance Company. Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensees of the Blue Cross Association. © ANTHEM and LUMENDS are registered trademarks. The Blue Cross name and symbol are registered service marks of the Blue Cross Association. THIS 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.

<sup>1</sup> First dollar coverage prorated the first year when effective date is not January 1. \*Offered by Anthem Blue Cross \*\*Offered by Anthem Blue Cross Life and Health Insurance Company.



# Option: Your employees may want to switch EmployeeChoice plans

## Five distinct plans + the ability to offer another carrier's HMO

If your needs have changed in the past year, your employees have the opportunity to change plans if they need more coverage or more affordable options — with no underwriting required. Five plans are available in your portfolio with network discounts — you still decide how many to offer. See the “What’s Changing?” section of this CD for rates and to access the Medical Plan Change Request form.

		<b>PPO \$35 Copay GenRx**</b> A unique, generic-only prescription design allows this plan to provide comprehensive coverage at budget-friendly prices.	<b>PPO \$30 Copay*</b> This top-selling, mid-range plan offers an ideal balance between cost and comprehensive benefits.	<b>Premier PPO \$20 Copay*</b> This high-end plan features rich benefits and the most comprehensive coverage.	<b>PPO 2400 (HSA-Compatible)**</b> This plan combines health coverage, financial strategy options and HSA compatibility.	<b>Saver HMO*</b> This plan is ideal for those who want the simplicity and predictability of HMO coverage. <sup>4</sup>
<b>Annual Deductible</b>		\$500 per member 2-member maximum	\$500 per member 2-member maximum	\$250 per member 2-member maximum	\$2,400 per member \$4,800 family aggregate <sup>1,3</sup>	\$1,500 per member Applies to inpatient and outpatient facility services, ambulatory surgical centers and dialysis centers except medical emergencies.
<b>Annual Out-of-Pocket Maximum<sup>2</sup></b>  Includes annual deductible	<b>In-Network</b>	\$4,000 per member 2-member maximum	\$4,000 per member 2-member maximum	\$3,000 per member 2-member maximum	\$3,600 per member \$5,500 family aggregate <sup>1,3</sup>  Members are responsible for all charges over the allowable amount when they use non-participating providers.	\$2,250 per member \$4,500 family aggregate <sup>3</sup>
	<b>Out-of-Network</b>	Anthem Blue Cross payment of \$10,000 per member's covered expenses	Anthem Blue Cross payment of \$10,000 per member's covered expense	\$5,000 per member 2-member maximum		Not applicable
<b>Office Visits</b>	<b>In-Network</b>	\$35 copay first 12 visits per member 45% of negotiated fee for additional visits (not subject to deductible)	\$30 copay first 12 visits per member 45% of negotiated fee for additional visits (not subject to deductible)	\$20 copay first 12 visits per member 40% of negotiated fee for additional visits (not subject to deductible)	\$35 office visit copay (subject to deductible)	\$20 copay (not subject to deductible)
	<b>Out-of-Network</b>	50% of negotiated fee plus 100% of excess charges (not subject to deductible)	50% of negotiated fee plus 100% of excess charges (not subject to deductible)	40% of customary and reasonable charges, plus 100% of excess charges (not subject to deductible)	50% of negotiated fee plus 100% of excess charges (subject to deductible)	Not covered
<b>Professional Services</b> Includes maternity, diagnostic lab and X-rays	<b>In-Network</b>	35% of negotiated fee	30% of negotiated fee	20% of negotiated fee	20% of negotiated fee	No charge (maternity services subject to the office visit copay)
	<b>Out-of-Network</b>	50% of negotiated fee plus 100% of excess charges	50% of negotiated fee plus 100% of excess charges	40% of customary and reasonable charges, plus 100% of excess charges	50% of negotiated fee plus 100% of excess charges	Not covered
<b>Emergency Care</b> \$100 emergency room copayment for each visit (waived if admitted)	<b>In-Network</b>	35% of negotiated fee	30% of negotiated fee	20% of negotiated fee	20% of negotiated fee	No charge
<b>Hospital Inpatient and Outpatient</b>	<b>Participating Hospitals</b>	35% of negotiated fee	30% of negotiated fee	20% of negotiated fee	20% of negotiated fee	No charge after deductible
<b>Prescription Drugs</b> Amounts shown are copays for each 30-day supply; up to a 60-day supply is available through mail order.	<b>In-Network</b>	\$15 generic; 30% of negotiated fee for generic self-administered injectable drugs, except insulin	\$15 generic; \$25 brand-name after annual \$150 brand-name prescription drug deductible per member  30% of negotiated fee for self-administered injectable drugs, except insulin (subject to brand-name prescription drug deductible if applicable) <sup>6</sup>	\$15 generic; \$25 brand-name;  30% of negotiated fee for self-administered injectable drugs, except insulin <sup>5</sup>	\$10 generic; \$25 brand-name;  30% of negotiated fee for self-administered injectable drugs, except insulin <sup>5</sup>	\$10 generic; \$25 brand-name after annual \$150 brand-name prescription drug deductible per member  30% of negotiated fee for self-administered injectable drugs, except insulin (subject to brand-name prescription drug deductible if applicable) <sup>6</sup>
<b>Preventive Care</b>	<b>In-Network</b>	\$35 office visit copay (not subject to deductible) plus 35% of negotiated fee for all other covered services (after deductible)	\$30 office visit copay (not subject to deductible) plus 30% of negotiated fee for all other covered services (after deductible)	\$20 office visit copay (not subject to deductible) plus 20% of negotiated fee for all other covered services (after deductible)	\$35 office visit copay (not subject to deductible) plus 20% of negotiated fee for all other covered services (after deductible)	\$20 copay
<b>HealthyCheck<sup>SM</sup> Screening</b> Ages 7-adult Not subject to deductible	<b>In-Network</b>	\$25 or \$75 copay health screening options	\$25 or \$75 copay health screening options	\$25 or \$75 copay health screening options	\$25 or \$75 copay health screening options	Not covered
<b>Annual Physical Exam</b> Ages 7-adult Not subject to deductible	<b>In-Network</b>	Not covered	Not covered	\$20 office visit copay plus 20% of negotiated fee for related covered services plus 100% of negotiated fee amount in excess of the Anthem Blue Cross payment <sup>7</sup>	\$35 office visit copay plus 20% of negotiated fee for related covered services plus 100% of negotiated fee amount in excess of the Anthem Blue Cross payment <sup>7</sup>	Not covered

1 PPO 2400 plan annual deductible and annual out-of-pocket maximum: medical/pharmacy combined; in-network and out-of-network combined; certain payments do not apply.  
 2 Annual out-of-pocket maximum: Expenses that contribute to the maximum copayment limit 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 Per family amount is aggregate, i.e., if one or more family member's eligible covered expenses (combined) meet this amount, the requirement is satisfied for all covered family members.

4 Served by the Anthem Blue Cross HMO (CaliforniaCare) network, which is available in most counties.  
 5 Prescription drugs: Members may select a brand-name drug when a generic drug is available if the physician writes a "dispense as written" or "do not substitute" prescription.  
 6 Prescription drugs: 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. The amount does not apply to the member's brand-name deductible.

7 Annual physical exam: Maximum annual Anthem Blue Cross payment of \$200 for members covered more than six months; \$100 for members covered six months or less. Refer to each plan's Combined Evidence of Coverage and Disclosure Form or Certificate for full details.  
 Note: A high-deductible health plan is not a Health Savings Account (HSA). An HSA, which must be established for tax-advantaged treatment, is a separate arrangement between the individual and a bank or other qualified institution. Consultation with a tax advisor is recommended.