



SIMPLE & CONSISTENT

Small Group Employee Elect Classic HMO Plan

Helping you stay healthy all year long

Predictable costs

Comprehensive coverage

Classic HMO: a healthy balance of benefits and value

It's all about you.

- You receive unlimited lifetime coverage for most in-network benefits
- You have predictable, low out-of-pocket costs and no annual medical deductible
- You choose your own medical group and primary care doctor from our large network
- You get the freedom from claim filing when using a network provider

Your plan is packed with valuable programs and services.

360° Health® is our unique health services program designed to help you achieve your own personal healthy best.

360° Health is a set of resources, programs, tools and services that we've brought together to surround you with a complete support environment. It can help you take care of yourself no matter what stage of health you're in and help you make informed health care decisions. It offers four levels of added support and engagement. *All at no additional cost!*

360° Health offers:

- 1** *Level one starts with education. **Health Resources***
From our website, and through Healthy Living, powered by WebMD®, you get access to easy-to-use, personalized online tools and trusted health information to help you make more informed health care decisions. Plus our online lifestyle centers can point you to the health information that matters most to you.
- 2** *Level two builds in key tools and discounts to maximize your health care dollars. **Health Extras***
Through our SpecialOffers program those extras include discounts on health and wellness products and certain alternative medicine services, plus access to online health programs.
- 3** *The third level offers guidance so you can get help when you need care or it can simply help you achieve your wellness goals. **Health Guidance***
Our 24/7 NurseLine offers access to qualified registered nurses anytime to help you decide whether a problem requires medical attention, so you can get the appropriate level of care and avoid unnecessary worry. Programs like MyHealth Assessment help you take an honest look at your health, plus there are tools to help guide you as you make important care decisions.
- 4** *And finally, assistance for members with challenging health needs. **Health Management***
Members with acute or chronic health conditions like asthma, diabetes, coronary artery disease, chronic obstructive pulmonary disease and heart failure get an additional, specialized level of support.

We're dedicated to improving your health.

With Anthem Blue Cross, you'll have peace of mind knowing that you're covered by one of the most trusted names in health care coverage, and that you're getting more value in so many ways. While we've changed our name from Blue Cross of California to Anthem Blue Cross, we still have the same commitment to you that we've had to all Californians over the last 70 years — to deliver high-quality, affordable health coverage and help you be as healthy as you can be. As the health care plan more Californians depend on, we look forward to serving your health care needs.

Have a question? We're here to help. Just call Small Group Customer Service at 800-627-8797.

Coverage you can trust. An ideal balance of benefits and value. That's what makes our Classic HMO Plan Simple & Consistent.

Your plan is easy to use

Your Anthem Blue Cross HMO plan coordinates health care services with you, your participating medical group and your primary care doctor.

Choose a doctor

When enrolling in this plan, you choose a doctor for yourself (and for each enrolled family member) from a participating medical group in our network. The doctor you choose is called your primary care physician, and this doctor is responsible for managing your health care needs. Generally, primary care doctors specialize in internal medicine, general practice, family practice or pediatrics.

Get medical care

Just call your primary care doctor, and he or she will help you get the care you need. Women may go to an OB/GYN specialist in our Anthem Blue Cross HMO network without a referral. To receive care provided by other specialists, you will need a referral from your participating medical group before you receive services. This includes hospitalizations, except in emergencies.

In an emergency

If you need emergency care, call 911 or go to the nearest emergency room. If you have an emergency condition and are admitted to the hospital, you or a member of your family must notify your primary care doctor within 48 hours.

SpeedyReferralSM and DirectAccess programs

Many medical groups participate in these two programs. SpeedyReferral makes the referral process faster and easier. DirectAccess allows you to self-refer to participating doctors who specialize in allergy, dermatology and ear/nose/throat health conditions. Before contacting a specialist directly, confirm that your participating medical group participates in the program.

Small Group Classic HMO Plan

All amounts listed are the member's responsibility to pay after deductible(s), unless otherwise noted.

CORE FEATURES	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible	None	None
Lifetime Covered Charges Paid by Anthem Blue Cross	Unlimited (in-network only, unless medical emergency)	Not applicable
Annual Out-of-Pocket Maximum¹ Per family amount is aggregate, i.e., when one or more family members' eligible covered expenses (combined) meet this amount, the requirement is satisfied for all covered family members	\$1,750 per member \$3,500 per family (one or more members-aggregate) Certain member payments do not apply	Not applicable
Office Visits Includes office visits for maternity	\$20 copay	Not covered
Other Professional Services Includes maternity, diagnostic lab and X-rays	No charge	Not covered
Hospital Inpatient Facility Services Pre-service Review required	\$250 copay per admission	Not covered, except for emergency services
Hospital Inpatient Professional Services (lab, physician, anesthesia)	No charge	Not covered, except for emergency services
Outpatient Facility Services Pre-service Review required for certain surgical services and diagnostic procedures	20% of negotiated fee	Not covered, except for emergency services
Ambulatory Surgical Centers and Dialysis Centers Pre-service Review required	20% copay	Not covered, except for emergency services
Prescription Drugs² 30-day supply retail; up to a 60-day supply available through mail order (amounts shown apply to each 30-day supply)	Generic: \$10 copay Brand-name if generic not available: \$25 copay after \$150 brand-name prescription drug deductible Brand-name if generic is available: \$10 copay plus the difference in cost between brand-name drug and generic-equivalent after \$150 brand-name prescription drug deductible Self-injectable (except insulin): 30% of negotiated fee (subject to brand-name prescription drug deductible, if applicable)	50% of drug limited fee schedule plus 100% of excess charges if filled within California after annual \$150 brand-name prescription drug deductible per member, in-network and out-of-network combined Mail order not available

¹ Services that do not apply to the annual out-of-pocket maximum include, but are not limited to: copay paid or the brand-name prescription drug deductible applied under the pharmacy benefit; infertility copay; copay for not obtaining pre-service review; non-covered services.

² Infertility Drugs: Infertility drug lifetime maximum Anthem Blue Cross payment is \$1,500 in-network and out-of-network combined. All 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 the generic copay plus the difference in cost between the brand-name drug and the generic-equivalent drug. The amount paid does not apply to the member's brand-name deductible.

This is an overview of coverage. A comprehensive description of coverage, benefits and limitations is contained in the Combined Evidence of Coverage and Disclosure Form. Review the Exclusions and Limitations prior to applying for coverage.

ADDITIONAL FEATURES	IN-NETWORK	OUT-OF-NETWORK
Well-Baby Immunizations and Adult Screening Tests	\$20 copay per office visit	Not covered
Emergency Care	No charge	No charge
· Professional Services		
· Outpatient Hospital Services	\$100 emergency room copay - waived if admitted	\$100 emergency room copay - waived if admitted
Ambulance	No charge if ordered by the Primary Care Physician or in an emergency	Not covered, except for medical emergency services or authorized referral
Skilled Nursing Facility 100 days per year in a two-bed room Pre-service Review required	No charge	Not covered
Home Health Care Up to 3 two-hour visits per day, Pre-service Review required	No charge if ordered by the Primary Care Physician	Not covered
Physical/Occupational Therapy Up to 60 consecutive days following an illness or injury	No charge if ordered by the Primary Care Physician	Not covered
Chemical Dependency/Inpatient* Detoxification for alcohol or drug abuse (acute stage only)	\$250 copay per admission for inpatient services	Not covered
Mental Health/Outpatient Professional Services* One visit per day, 20 visits per year	\$20 copay	Not covered
Infusion Therapy/Chemotherapy Pre-service Review required		
· Professional Services	No charge	Not covered
· Facility Fees	20% copay	Not covered
Infertility Services	50% copay	Not covered

* Except for coverage of severe mental illness and serious emotional disturbances of a child.

Exclusions and Limitations

Following is an abbreviated list of exclusions and limitations; please see the Combined Evidence of Coverage and Disclosure Form for comprehensive details.

- Any amounts in excess of maximums stated in the Combined Evidence of Coverage and Disclosure Form.
- Services or supplies that are not medically necessary.
- Services received before your effective date.
- Services received after your coverage ends.
- Any conditions for which benefits can be recovered under any workers' compensation law or similar law.
- Services you receive for which you are not legally obligated to pay.
- Services for which no charge is made to you in the absence of insurance coverage.
- Services not listed as covered in the Combined Evidence of Coverage and Disclosure Form.
- Services from relatives.
- Vision care except as specifically stated in the Combined Evidence of Coverage and Disclosure Form.
- Eye surgery performed solely for the purpose of correcting refractive defects.
- Hearing aids.
- Sex changes.
- Dental and orthodontic services except as specifically stated in the Combined Evidence of Coverage and Disclosure Form.
- Cosmetic surgery.
- Routine physical examinations except as specifically stated in the Combined Evidence of Coverage and Disclosure Form.
- Treatment of mental or nervous disorders (including nicotine use) or psychological testing, except as specifically stated in the Combined Evidence of Coverage and Disclosure Form.
- Custodial care.
- Experimental or investigational services.
- Services provided by a local, state or federal government agency, unless you have to pay for them.
- Diagnostic admissions.
- Telephone or facsimile machine consultations.
- Personal comfort items.
- Health club memberships.
- Any services to the extent you are entitled to receive Medicare benefits for those services without payment of additional premium for Medicare coverage.
- Food or dietary supplements, except for formulas and special food products to prevent complications of phenylketonuria (PKU).
- Genetic testing for non-medical reasons or when there is no medical indication or no family history of genetic abnormality.
- Outdoor treatment programs.
- Replacement of prosthetics and durable medical equipment when lost or stolen.
- Any services or supplies provided in connection with a surrogate pregnancy.
- Immunizations for travel outside the United States.
- Educational services except as specifically stated in the Combined Evidence of Coverage and Disclosure Form.
- Infertility services (including sterilization reversal) except as specifically stated in the Combined Evidence of Coverage and Disclosure Form.
- Care provided in a non-contracting hospital.
- Private duty nursing.
- Services primarily for weight reduction except medically necessary treatment of morbid obesity.
- Outpatient drugs, medications or other substances dispensed or administered in any outpatient setting.
- Contraceptive devices unless your physician determines that oral contraceptive drugs are not medically appropriate.
- Care not authorized by your PMG or IPA.
- Amounts in excess of customary and reasonable charges for non-emergency care rendered by a non-participating provider without an authorized referral from your PMG or IPA.
- Rehabilitative care, such as physical therapy, occupational therapy and speech therapy, except as specifically stated in the Combined Evidence of Coverage and Disclosure Form.
- Conditions of the jaw or teeth secondary to malocclusion or orthognathic conditions.
- Growth hormone treatment.
- Acupuncture/acupressure.
- Durable Medical Equipment except as specifically stated in the Combined Evidence of Coverage and Disclosure Form.

General Provisions

Member Privacy

Our complete **Notice of Privacy Practices** provides a comprehensive overview of the policies and practices we enforce to preserve our members' privacy rights and control use of their health care information, including: the right to authorize release of information; the right to limit access to medical information; protection of oral, written and electronic information; use of data; and information shared with employers. This notice can be downloaded from our website at anthem.com/ca or obtained by calling Small Group Customer Service at 800-627-8797.

Utilization Review

The Anthem Blue Cross Utilization Review Program helps members receive coverage for appropriate treatment in the appropriate setting. Four review processes are included: 1) Pre-service Review assesses medical necessity before services are provided; 2) Admission Review determines at the time of admission if the stay or surgery is Medically Necessary in the event Pre-service Review is not conducted; 3) Continued Stay Review determines if a continued stay is Medically Necessary; 4) Retrospective Review determines if the stay or surgery was Medically Necessary after care has been provided if none of the first three reviews were performed. Utilization Review is not the practice of medicine or the provision of medical care to you. Only your doctor can provide you with medical advice and medical care.

Grievances

All complaints and disputes relating to a member's coverage must be resolved in accordance with Anthem Blue Cross' grievance procedure. You can report your grievance by phone or in writing; see your Anthem Blue Cross ID card for the appropriate contact information. All grievances

received by Anthem Blue Cross that cannot be resolved by phone (when appropriate) to the mutual satisfaction of the member and Anthem Blue Cross will be acknowledged in writing, together with a description of how Anthem Blue Cross proposes to resolve the grievance. Grievances that cannot be resolved by these procedures shall be resolved as indicated through binding arbitration, or if the plan you are covered under is subject to the Employee Retirement Income Security Act of 1974 (ERISA), in compliance with ERISA rules.

If the group is subject to ERISA, and a member disagrees with Anthem Blue Cross' proposed resolution of a grievance, the member may submit an appeal by phone or in writing, by contacting the phone number or address printed on the letterhead of the Anthem Blue Cross response letter.

For the purposes of ERISA, there is one level of appeal. For urgent care requests for benefits, Anthem Blue Cross will respond within 72 hours from the date the appeal is received. For pre-service requests for benefits, the member will receive a response within 30 calendar days from the date the appeal is received. For post-service claims, Anthem Blue Cross will respond within 60 calendar days from the date the appeal is received.

If the member disagrees with Anthem Blue Cross' decision on the appeal, the member may elect to have the dispute settled through alternative resolution options, such as voluntary binding arbitration.

Department of Managed Health Care

The California Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at 800-627-8797 and use your health plan's grievance process before contacting the DMHC. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the DMHC for assistance. Your case may also be eligible

for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency or urgent medical services. The DMHC also has a toll-free telephone number (888-HMO-2219), and TDD line (877-688-9891) for the hearing- and speech-impaired. The department's Internet website, www.hmohelp.ca.gov, has complaint forms, IMR application forms and instructions online.

Binding Arbitration

If the plan is subject to ERISA, any dispute involving an adverse benefit decision must be resolved under ERISA claims procedure rules, and is not subject to mandatory binding arbitration. Members may pursue voluntary binding arbitration after they have completed an appeal under ERISA rules. If the member has another dispute that does not involve an adverse benefit decision, or if the group does not provide a plan that is subject to ERISA, the following provisions apply: any and all disputes between the employer and/or the member and Anthem Blue Cross, including but not limited to claims of medical malpractice, must be resolved by binding arbitration (not by lawsuit or trial by court or jury or other court process, except as California's law provides for judicial review of arbitration proceedings), if the amount in dispute exceeds the jurisdictional limit of the Small Claims Court. Under this coverage, both the member and Anthem Blue Cross are giving up the right to participate in class arbitration or have any dispute decided by a court or jury trial.

Medicare

Under TEFRA/DEFRA, Medicare is the primary coverage for groups of less than 20 employees. Anthem Blue Cross coverage is considered primary coverage for groups of 20 or more employees. This Anthem Blue Cross coverage is not a supplement to Medicare, but provides benefits according to the non-duplication of Medicare clause.

If Medicare is a member's primary health plan, Anthem Blue Cross will not provide benefits that duplicate any benefits you are entitled to receive under Medicare.

This means that when Medicare is the primary health coverage, benefits are provided in accordance with the benefits of the plan, less any amount paid by Medicare. If you are entitled to Part A and B of Medicare, you will be eligible for non-duplicate Medicare coverage, with supplemental coordination of benefits. However, if you are required to pay the Social Security Administration an additional premium for any part of Medicare, then the above policy will only apply if you are enrolled in that part of Medicare. Note: Medicare-eligible employees/dependents enrolled in plans where Medicare is primary may obtain an Individual Anthem Blue Cross Medicare Supplement plan with the pre-existing condition exclusion waived.

Coordination of Benefits

The benefits of a member's plan may be reduced if the member has other group health, dental, drug or vision coverage, so that benefits and services the member receives from all group coverages do not exceed 100 percent of the covered expense.

Third-Party Liability

If a member is injured, the responsible party may be legally obligated to pay for medical expenses related to that injury. Anthem Blue Cross may recover benefits paid for medical expenses if the member recovers damages from a legally liable third-party. Examples of third-party liability situations include car accidents and work-related injuries.

Voiding Coverage for False and Misleading Information

False or misleading information or failure to submit any required enrollment materials may form the basis for voiding coverage from the date a plan was issued or retroactively adjusting the premium to what it would have been if the correct information had been furnished. No benefits will be paid for any claim submitted if coverage is made void. Premiums already paid for the time period for which coverage was rescinded will be refunded, minus any claims paid.

Incurred 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.



Blue Cross of California
Commercial
HMO/POS Combined

The National Committee for Quality Assurance (NCQA) has awarded Blue Cross of California's Commercial HMO/POS products combined its highest accreditation status of **Excellent** for service and clinical quality that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement. Blue Cross' Excellent Accreditation went into effect on November 23, 2005.

Goods and services available through discount programs are not benefits of coverage. Anthem Blue Cross does not endorse or recommend any goods or services provided at a discount by these vendors or practitioners. These programs may be changed or withdrawn at any time without notice by the offering vendor or practitioner.

Classic HMO Plan is offered by Anthem Blue Cross.

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