



Benefits You Can Count On

Anthem BC PPO (non-CA residents)

San Bernardino Community

College District





February 17, 2010

Dear San Bernardino Community College District employee,

Few decisions you make are as important as choosing the right health care plan. With that thought in mind, you've received this booklet containing an overview of benefits available to you, as well as information designed to help you make better-informed health care decisions. Plus, information about our many value-added, health-related programs is included.

All our plans are designed to allow you convenient access to medical facilities and services. Visit our website www.anthem.com/ca to access health care decision-making tools and information about alternative health and wellness programs.

Enrolling is easy, and so is getting the care you need. You can depend on our extensive network of licensed health care professionals and quality hospitals for patient-focused care. If you need help understanding how your plan works, our dedicated Customer Service staff is available Monday through Friday from 8:00 a.m. to 12 midnight to answer questions. Simply call the toll-free Customer Service number printed on your member ID card. On weekends, our automated system is available for benefit and eligibility information.

Welcome to the company that provides you with the health information resources you need and access to the high quality health care you deserve.

Anthem Blue Cross

Notice of Privacy Practices

Effective July 1, 2007



THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We keep the health and financial information of our current and former members private as required by law, accreditation standards, and our rules. This notice explains your rights. It also explains our legal duties and privacy practices. We are required by federal law to give you this notice.

Your Protected Health Information

We may collect, use, and share your Protected Health Information (PHI) for the following reasons and others as allowed or required by law, including the HIPAA Privacy rule:

For Payment: We use and share PHI to manage your account or benefits; or to pay claims for health care you get through your plan. For example, we keep information about your premium and deductible payments. We may give information to a doctor's office to confirm your benefits.

For Health Care Operations: We use and share PHI for our health care operations. For example, we may use PHI to review the quality of care and services you get. We may also use PHI to provide you with case management or care coordination services for conditions like asthma, diabetes, or traumatic injury.

For Treatment Activities: We do not provide treatment. This is the role of a health care provider such as your doctor or a hospital. But, we may share PHI with your health care provider so that the provider may treat you.

To You: We must give you access to your own PHI. We may also contact you to let you know about treatment options or other health-related benefits and services. When you or your dependents reach a certain age, we may tell you about other products or programs for which you may be eligible. This may include individual coverage. We may also send you reminders about routine medical checkups and tests.

To Others: You may tell us in writing that it is OK for us to give your PHI to someone else for any reason. Also, if you are present, and tell us it is OK, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are not present, if it is an emergency, or you are not able to tell us it is OK, we may give your PHI to a family member, friend or other person, if sharing your PHI is in your best interest.

As Allowed or Required by Law: We may also share your PHI, as allowed by federal law, for many types of activities. PHI can be shared for health oversight activities. It can also be shared for judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and to coroners, funeral directors or medical examiners (about decedents). PHI can also be shared for certain reasons with organ donation groups, for research, and to avoid a serious threat to health or safety. It can be shared for special government functions, for workers' compensation, to respond to requests from the U.S. Department of Health and Human Services and to alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or other crimes. PHI can also be shared as required by law.

If you are enrolled with us through an employer-sponsored group health plan, we may share PHI with your group health plan. We and/or your group health plan may share PHI with the sponsor of the plan. Plan sponsors that receive PHI are required by law to have controls in place to keep it from being used for reasons that are not proper.

Authorization: We will get an OK from you in writing before we use or share your PHI for any other purpose not stated in this notice. You may take away this OK at any time, in writing. We will then stop using your PHI for that purpose. But, if we have already used or shared your PHI based on your OK, we cannot undo any actions we took before you told us to stop.

Your Rights

Under federal law, you have the right to:

- Send us a written request to see or get a copy of certain PHI or ask that we correct your PHI that you believe is missing or incorrect. If someone else (such as your doctor) gave us the PHI, we will let you know so you can ask them to correct it.
- Send us a written request to ask us not to use your PHI for treatment, payment or health care operations activities. We are not required to agree to these requests.
- Give us a verbal or written request to ask us to send your PHI using other means that are reasonable. Also let us know if you want us to send your PHI to an address other than your home if sending it to your home could place you in danger.
- Send us a written request to ask us for a list of certain disclosures of your PHI.

Call Customer Service at the phone number printed on your identification (ID) card to use any of these rights. They can give you the address to send the request. They can also give you any forms we have that may help you with this process.

How We Protect Information

We are dedicated to protecting your PHI. We set up a number of policies and practices to help make sure your PHI is kept secure.

We keep your oral, written, and electronic PHI safe using physical, electronic, and procedural means. These safeguards follow federal and state laws. Some of the ways we keep your PHI safe include offices that are kept secure, computers that need passwords, and locked storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. The policies limit access to PHI to only those employees who need the data to do their job. Employees are also required to wear ID badges to help keep people who do not belong out of areas where sensitive data is kept. Also, where required by law, our affiliates and non-affiliates must protect the privacy of data we share in the normal course of business. They are not allowed to give PHI to others without your written OK, except as allowed by law.

Potential Impact of Other Applicable Laws

HIPAA (the federal privacy law) generally does not preempt or override other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to provide you with more privacy protections, then we must also follow that law in addition to HIPAA.

Complaints

If you think we have not protected your privacy, you can file a complaint with us. You may also file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services. We will not take action against you for filing a complaint.

Contact Information

Please call Customer Service at the phone number printed on your ID card. They can help you apply your rights, file a complaint or talk with you about privacy issues.

Copies and Changes

You have the right to get a new copy of this notice at any time. Even if you have agreed to get this notice by

electronic means, you still have the right to a paper copy. We reserve the right to change this notice. A revised notice will apply to PHI we already have about you as well as any PHI we may get in the future. We are required by law to follow the privacy notice that is in effect at this time. We may tell you about any changes to our notice in a number of ways. We may tell you about the changes in a member newsletter or post them on our website. We may also mail you a letter that tells you about any changes.

State Notice of Privacy Practices

As we told you in our HIPAA notice, we must follow state laws that are more strict than the federal HIPAA privacy law. This notice explains your rights and our legal duties under state law.

Your Personal Information

We may collect, use and share your nonpublic personal information (PI) as described in this notice. PI identifies a person and is often gathered in an insurance matter. PI could also be used to make judgments about your health, finances, character, habits, hobbies, reputation, career, and credit.

We may collect PI about you from other persons or entities such as doctors, hospitals or other carriers.

We may share PI with persons or entities outside of our company without your OK in some cases.

If we take part in an activity that would require us to give you a chance to opt-out, we will contact you. We will tell you how you can let us know that you do not want us to use or share your PI for a given activity.

You have the right to access and correct your PI.

We take reasonable safety measures to protect the PI we have about you.

A more detailed state notice is available upon request. Please call the phone number printed on your ID card.

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

This Notice is provided by the following companies: Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company.

Anthem Blue Cross is the trade name of Blue Cross of California. Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company are independent licensees of the Blue Cross Association. © ANTHEM is a registered trademark. © The Blue Cross name and symbol are registered marks of the Blue Cross Association.

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Plan Overview



Welcome to Your BC PPO Plan

Enrolling in BC PPO gives you important advantages like improved access to affordable and quality health care. We're committed to the idea that true service begins and ends with understanding *and* responding to your needs!

Our premier services and comprehensive benefits cover more than the most basic health care needs. With access to our extensive, nationwide network of doctors and hospitals, you and your family can expect ease and convenience when you need our services. You'll gain empowering health information 24 hours a day, seven days a week with quick access to our website (anthem.com/ca), and, in addition to your health care benefits, you'll receive health and wellness services and healthy lifestyle programs.

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.

Welcome to your BC PPO plan. Our goal is to provide you with the kind of products, services and information you need to make a difference in your health care.

Advantages – at a glance

As you review your member enrollment kit, you will learn about the many advantages of BC PPO and how this plan will best meet your personal and health care needs. Here are just a few of the highlights of our BC PPO plan:

- Comprehensive benefits and easy access to a large network of providers and hospitals
- Your choice to receive your health care from any licensed physician, specialist or health care facility
- Freedom from claim filing when using a network provider, since our PPO network providers bill us directly
- Emergency care is covered anywhere in the world through an international PPO network, 24 hours a day, seven days a week
- Toll-free Customer Service number for quick answers to all your benefits questions
- Fast and convenient access to health care information on our website (anthem.com/ca), 24 hours a day, seven days a week

We know that choosing your health care is an important decision. We look forward to enrolling you as a member.

Your BC PPO Plan

How Your BC PPO Preferred Provider Plan Works

Your nationwide Preferred Provider Organization (PPO) is a type of health care coverage that gives you the freedom to choose any licensed health care provider for covered services. Because your employer is based in California, your plan is administered by Anthem Blue Cross Life and Health Insurance Company.

As part of the BC Plan, you may have a calendar deductible, along with deductibles for admission to non-participating facilities, emergency room services and ambulatory surgery facilities. You also have a percentage of cost, which is your portion to pay, and may have an office visit copay.

Participating Health Care Providers

The BlueCard® network is made up of the Blue Cross Association plan provider network nationwide. The two types of participating health care providers are PPO health care providers, who are physicians and hospitals that participate in the BlueCard network, and traditional health care providers and institutions. Or, you can choose a non-network provider (a provider who does not belong to the BlueCard network), but your costs will be higher.

Using your plan is simple!

1. After enrolling in a BC PPO plan, you select health care providers for yourself and each enrolled family member from our BlueCard network of contracted providers.
2. Or, you may choose to go to an out-of-network provider (a provider who does not belong to the BlueCard network) and pay a larger share of the cost.

You can significantly reduce your out-of-pocket costs by visiting a BlueCard network health care provider for covered services. These lower costs are due to negotiated rates that PPO health care providers agree to accept instead of their typical fees. PPO network health care providers will file a claim for you and then may bill you for the remaining portion of the costs. However, you may need to pay applicable copays and deductibles when you receive care.

Traditional health care providers might not participate in a BlueCard network but have agreed to perform services at a discounted rate for BC PPO members. Typically, you would go to a traditional health care provider if there are no BlueCard network health care providers in your area who can perform the medical care you need. Traditional health care providers do not require payment, other than

applicable copays, at time of service and will file the claim for you. You can reduce your out-of-pocket expenses by visiting a traditional health care provider rather than going to a non-network health care provider for covered services.

Please note, if your member ID card displays a PPO suitcase logo, you will pay the least amount for services from a PPO health care provider. However, if your member card does not display the PPO suitcase logo, you must go to a traditional health care provider in order to pay the least amount for your services.

For additional information regarding PPO and traditional health care providers, please refer to your Certificate of Insurance or call Customer Service at the toll-free number on your ID card.

Non-network Health Care Providers

Non-network health care providers do not belong to a BlueCard network and do not offer services at a discounted rate like PPO network health care providers.

When Anthem Blue Cross Life and Health Insurance Company pays for services from a non-network health care provider, you are responsible for a higher, out-of-network percentage of cost and any charges in excess of the covered expense.

In addition to higher costs, you will likely pay more deductibles when using a non-network health care provider. A non-network health care provider may also require payment for services when you receive care.

How Do I Choose a Provider?

Choosing your participating health care provider is easy!

You can locate BC PPO and traditional health care providers at www.bluecares.com.

You may call 800-810-BLUE (2583), toll-free, to locate participating physicians throughout the USA and facilities in several international cities.

Will I Get an ID Card?

After enrolling in the BC PPO Plan, your member ID card will arrive shortly thereafter. Always keep your member ID card with you because it is proof of your coverage.

Your ID card lists:

- Your office visit copay amount (if applicable)
- The toll-free Customer Service phone number
- Additional benefits

How Do I Get Started Scheduling a Doctor Visit?

Once you have located a participating PPO health care provider, call the doctor's office to schedule an appointment.

What is My Annual Out-of-Pocket Maximum?

The Annual Out-of-Pocket Maximum refers to the maximum amount that you will have to pay for expenses covered under your BC PPO Plan. After you reach your Annual Out-of-Pocket Maximum, you will not have to pay coinsurance for some services for the rest of that calendar year. For a list of these services, please refer to the Certificate of Insurance.

What is My Certificate of Insurance?

Your Certificate of Insurance (Certificate) is an important document that explains the details of your health care benefits, policies and procedures, any limits to your coverage, what isn't covered and costs you will have to pay. Your Certificate will be available from your employer after enrollment.

What Will I Find in a Summary of Benefits?

The Summary of Benefits is a condensed listing of benefits highlighting your copay amounts, deductibles and any applicable benefit maximum amounts. You should refer to your Certificate for details about your particular plan.

How Do I File a Claim?

You will need to submit a claim to Anthem Blue Cross Life and Health Insurance Company if you receive services from a non-network health care provider.

We make it easy by offering you the following ways to obtain a claim form:

- Contact your employer
- Call Customer Service at the toll-free number on your ID card
- You may download and print a claim form by going to our website at anthem.com/ca.

Be sure to use a separate claim form for each patient and health care provider. For faster claim processing, please be sure you attach all necessary receipts.

Occasionally a claim is denied payment. If this happens, you and your physician will receive an explanation of denial. If you believe your claim should be paid, please call Customer Service at the toll-free number on your ID card. Customer Service will help you with step-by-step instructions on how you can appeal the denial. This information is also included in your Certificate.

How Do I Voice a Complaint and Appeal a Decision?

Know that you have options.

If you are dissatisfied with the care or service you have received, or you wish to appeal a denied treatment or claim, you may select one of several methods to submit your grievance or appeal to Anthem Blue Cross Life and Health Insurance Company.

- ***Member Issue Form***

Complete a "Member Issue Form," which can be obtained from your medical group or from Customer Service. The form can be faxed to Customer Service at 818-234-1089, or mailed to:
Anthem Blue Cross Life and Health
P.O. Box 4310
Woodland Hills, CA 91367

- ***Customer Service***

Call Customer Service at the phone number on your member ID card to submit a verbal grievance or appeal. Assistance is available for members with limited English proficiency or those with visual or communications impairment.

- ***Website***

Access the website at anthem.com/ca.

How to use the grievance website:

1. Go to anthem.com/ca.
2. Select *File a Grievance*.

What Does My Explanation of Benefits Tell Me?

After your claim is processed, you will receive an Explanation of Benefits (EOB). The EOB summarizes the services you received, how the claim was paid and what portion of the cost you will need to pay. The EOB is designed to provide you with the information you need to understand the medical costs you are responsible for and what costs will be taken care of by Anthem Blue Cross Life and Health. It's our way of continuing to provide you with quality Customer Service.

If you have any questions regarding the EOB, please contact Customer Service at the toll-free number on your EOB.

Tell Me About Your Medical Management Program

Anthem Blue Cross Life and Health conducts utilization review, which provides approval for non-emergency hospital admissions and inpatient surgery. Please call Anthem Blue Cross Life and Health at the toll-free number that is printed on your ID card and identified as the phone number "For Pre-Authorization or Pre-Service Review." You will need to call at least three days before your hospital admission or outpatient surgery.

You Talk, We Listen

You told us what you needed to better understand your health care – we responded with a listing of some of the more important benefits our members use, as well as informative and easy-to-use charts to help you make sense of your benefits and understand them when the needs arise.

BC PPO BENEFITS

BC PPO EMERGENCY CARE

As a BC PPO member, you are asked to follow these guidelines when you believe you need emergency care.

An emergency is a sudden, serious or unexpected illness, injury or health problem (including sudden and unexpected severe pain). This includes any illness, injury or health problem you reasonably believe could endanger your health if you don't receive medical care right away. **As a BC PPO member, you are covered 24 hours a day, seven days a week for emergency services anywhere in the world.**

Your Benefits

Medical emergency facility

How To Receive Them

Because medical emergencies require immediate attention, call 911 (if you are in an area where the system is established and operating) or go for immediate treatment at the closest emergency facility. If you are not admitted, you will need to pay the emergency room deductible.

Subject to the availability of network health care providers on staff at the hospital, you may request that all services be performed by network providers to incur less cost.

Emergency admission to a PPO network hospital

If you are admitted to a network hospital, your emergency room deductible will be waived. The hospital will notify us of your admission. We will then coordinate your care with your PPO network physician.

Emergency admission to a non-network hospital

If you are admitted to a non-network hospital, your emergency room deductible will be waived.

You, your family or the hospital should contact us within 24 hours of your admission. The Customer Service toll-free number is printed on your member ID card.

BC PPO NON-EMERGENCY INPATIENT HOSPITAL SERVICES

Your BlueCard® network physician helps ensure that your hospital admission for non-emergency services and inpatient surgery will be covered.

Your Benefits

Hospital Services

How To Receive Them

Before you're admitted to a hospital for non-emergency services, including hospital admission for inpatient surgery, your BlueCard network physician will make sure your admission will be considered medically necessary.

BC PPO WHEN TRAVELING OR TEMPORARILY RESIDING OUTSIDE YOUR HOME STATE

If you are traveling outside your home state or out of the country, you and your enrolled dependents can access care from Blue Cross Association participating health care providers. We've got you covered when you're away from home!

Your Benefits

Emergency care when outside your home state

You are covered 24 hours a day, seven days a week, regardless of your location.

Please note: Your benefits may only cover emergency care services when you are outside the USA. Please refer to your Certificate of Insurance for benefit details.

How To Receive Them

If you have a medical emergency in the USA, call the 911 emergency response system (if you are in an area where the system is established and operating) or seek immediate medical attention at the closest emergency facility. If you are not admitted to the hospital, you may be billed for the emergency room deductible.

If admitted, your emergency room deductible will be waived. Please contact us within 48 hours of your admission. The Customer Service toll-free number is printed on your ID card.

- If you receive services from a facility in the BlueCard network, the health care provider will file the claim for you.
- If you receive services from a non-network health care provider, you may need to pay for the emergency services when you receive them. You would then file a claim to the local Blue Cross Association Plan in the state where you received services. Please save all relevant statements and attach them to the claim form for reimbursement.

Protection when traveling or temporarily living outside your home state

BlueCard® is a program of the Blue Cross Association that enables members traveling outside California to access a broader network of doctors and hospitals at discounted rates through other participating Blue Cross plans.

The national program provides continued PPO benefits for you and your enrolled dependents (even out-of-state students) when traveling or temporarily residing outside your home state.

To locate BlueCard network providers, just call toll-free 800-810-BLUE (2583). Please note that the number is printed on your ID card for handy reference.

You can also find Blue Cross Association PPO providers at anthem.com/ca.

- If you receive services from a provider in the national Blue Cross Association network, the provider will file the claim for you.
- If you receive services from a non-network PPO provider, you will need to pay for the medical services when you receive them. You would then file a claim to the local Blue Cross Association plan in the state where you received services. Please save all relevant statements and attach them to the claim form for reimbursement.

BC PPO WHEN TRAVELING OUTSIDE THE USA

Your Benefits

Inpatient services when traveling outside the USA

You may access international Blue Cross Association network hospitals for inpatient services.

Please note: Your benefits may only cover emergency care services when you are outside the USA. Please refer to your Certificate of Insurance for benefit details.

Outpatient emergency care when outside the USA

Always carry your ID card when traveling outside the USA.

You are covered 24 hours a day, seven days a week, regardless of your location.

How To Receive Them

Be prepared for the unexpected: call 800-810-BLUE (2583) before leaving the USA. A BlueCard Coordinator will provide you with a list of Blue Cross Association network hospitals in several international cities.

For inpatient care at a BlueCard network hospital, you pay only the applicable deductibles and copays. The provider files the claim for you.

For inpatient care at a non-network hospital, you will need to pay the hospital at the time you receive services and then submit a claim for reimbursement. To print a claim form, go to anthem.com/ca.

If you need emergency medical care, go to the nearest hospital. Call BlueCard at 800-810 BLUE (2583) or call collect 804-673-1177 if you are admitted to the hospital.

If you are not admitted to the hospital, you may be asked to pay for emergency services when you receive care. Before leaving the emergency facility, please request an itemized bill, which you will need to include when filing the claim to us.

For all outpatient and professional medical care, you pay the provider and submit a claim. To print a claim form, go to anthem.com/ca.

360° HEALTH®

360° Health® surrounds you with programs and services that help you get healthy, stay healthy and live better. It's a basic idea: the more you know, the healthier you can be. Instead of waiting for health problems (and their costs) to crop up, these programs can help you prevent them or keep them from getting worse. Many of the programs are online. To reach them, go to anthem.com/ca, register and log in with your username and password.

Whatever stage of health you're in, these core programs work together to support you.

MyHealth@Anthem® – Finding health information online can be like using a dictionary that's not alphabetized. This personalized site makes it easy to find the info that matters to you, manage your health and stay motivated.

24/7 NurseLine – Health questions and concerns don't keep regular business hours. When you need answers right away, you have direct, round-the-clock access to a registered nurse with an average of 19 years of nursing experience. It's toll free and always confidential. Just call the number listed on your ID card.

Future Moms – A healthy pregnancy may be the greatest gift you could give your baby. This award-winning maternity program gives you support – and educational information – for every stage of pregnancy.

SpecialOffers@Anthem – See all the discounts available to you for healthy living products and services, like fitness club memberships and LASIK.¹

Staying Healthy Reminders – You're busy. Very busy. So we'll help you remember to get those preventive tests, procedures and screenings that can mean so much to your health. Well-timed mailers targeted to your needs cover simple, potentially life-saving services ranging from cancer screenings and immunizations to tips for safe recreational activity.

ConditionCare – Chronic diseases need continuous attention. Thankfully, you're not alone when facing difficult cases of asthma, diabetes, chronic obstructive pulmonary disease, coronary artery disease or heart failure. If you qualify, you'll have your own registered nurse to help you self-manage your condition and help you improve your quality of life.

ComplexCare – This team of nurses specializes in helping people with specialty care needs who might be at risk for even bigger problems in the future. With one-on-one attention and coaching, your nurse will help you develop a personal care plan to reduce that risk.

¹ Vendors and offers are subject to change without prior notice. Anthem does not endorse and is not responsible for the products, services or information provided by the SpecialOffers vendors. Arrangements and discounts were negotiated between each vendor and Anthem for the benefit of our members.

DECISION SUPPORT TOOLS

Knowledge is power. The more you know, the easier it is to decide what to do. Once you're registered on anthem.com/ca, you'll have access to a world of health coverage and benefit information. Whether you're healthy or have medical problems, you'll find tools, resources and support to help you make smart decisions, such as:

MyAnthem™ – Your personalized benefits site. Most questions you have can be answered here.

- Find a doctor or facility
- View coverage and benefit information
- Review current and past claims
- Request new ID cards
- Print a temporary ID card
- Check dependent eligibility information
- Ask questions about your benefits
- And more

Coverage Advisor™ – Understand what health care services you might need and estimate the costs for those services.

Treatment Cost Advisor™ – View estimated costs for specific services, tests, doctor visits and medications.

Anthem Care Comparison – See quality and price ranges for common medical fees and information on inpatient and outpatient services and office visits.

SpecialOffers@Anthem – See all the discounts available to you for healthy living products and services, like fitness club memberships and LASIK.¹

MyHealth@Anthem® – Find tools and information to help you better evaluate and manage your health.

Registering is Easy

Log on to anthem.com/ca and select “Members,” then click the “Login” button and log in to gain confidential access to all of your accounts. Simply click on the relevant links.

¹ Vendors and offers are subject to change without prior notice. Anthem does not endorse and is not responsible for the products, services or information provided by the SpecialOffers vendors. Arrangements and discounts were negotiated between each vendor and Anthem for the benefit of our members.

Your Rights

A large part of protecting our valued partnership with you is looking after your legal rights, making clear your responsibilities as a member and ensuring the protection of your privacy. Please refer to your Certificate of Insurance (Certificate) for the exact terms and conditions of your coverage, including, but not limited to, explanations of Binding Arbitration, Third-party Liability and Privacy Practices.

Coordination of Benefits

If you have more than one group or group-type plan, the total amount of payments for medical care will not exceed 100 percent of charges for actual covered services.

For additional information regarding Coordination of Benefits, please refer to your Certificate.

Third-party Liability

Anthem Blue Cross Life and Health Insurance Company is entitled to reimbursement of benefits paid if you recover damages from a legally liable third party.

For complete information regarding Third-party Liability, please refer to your Certificate.

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents, including your spouse, because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if:

- You or your dependents lose eligibility for that other coverage, or
- If the employer stops contributing toward your or your dependents' other coverage.

You must request enrollment within 31 days after your or your dependents' other coverage ends or after the employer stops contributing toward the other coverage.

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. Please note that in the event of a marriage, you, your spouse and any dependents gained as a result of that marriage, such as the children of your new spouse, may enroll in the plan. Existing unenrolled dependents, such as your own natural children, do not have a special enrollment right in this situation. In the event of birth,

adoption or placement for adoption, you, your spouse and the newly born or adopted child may enroll in the plan. Existing unenrolled dependents do not have a special enrollment right in this situation. You must request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

To request a special enrollment or to obtain more information, please call the Customer Service telephone number listed on your ID card.

If your health plan is subject to California state law, any special enrollment rights that apply to an eligible spouse also apply to an eligible domestic partner, as defined by your health plan.

Pre-existing Condition Exclusion Notice

This plan imposes a pre-existing condition exclusion if you had a medical condition prior to this plan becoming effective. A waiting period may apply before this plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within a six-month period.

Generally, this six-month period ends the day before your coverage becomes effective. However, if you were subject to a coverage waiting period, the six-month period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy or to a child who is enrolled in the plan within 31 days after birth, adoption, or placement for adoption.

This exclusion may last up to six months from your first day of coverage or, if you were in a waiting period, from the first day of your waiting period.* However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition

exclusion if you have not experienced a significant break in coverage. The maximum allowable break in coverage is 180 days if your prior coverage was provided through an employer and ended because either:

- Your employment (or the person's employment through which you had this coverage) ended
- The availability of coverage through employment or sponsored by an employer has terminated, or
- An employer's contribution toward health coverage has terminated.

For prior coverage that was not provided through an employer, such as individual coverage or coverage through a government program such as Medicaid, the maximum allowable break in coverage is 63 days. Please see the following examples:

- **Example 1.** You lose employer group coverage on August 1 after having this coverage for three years, and obtain new coverage through another employer the following January 1 (after a lapse of five months). You will receive credit for your prior coverage because the lapse is less than the maximum 180 days allowed. If your new plan includes a six-month pre-existing condition exclusion, you will not be subject to this exclusion because you had at least six months of prior creditable coverage.
- **Example 2.** You lose coverage under an individual plan on August 1 after having this coverage for three years. You obtain new coverage through an employer on the following November 1 (after a lapse of three months). You will not receive credit for your prior individual coverage because your lapse exceeded 63 days. If your new plan includes a six-month pre-existing condition exclusion, you will be subject to this exclusion and any pre-existing conditions you have will not be covered until the following May 1.

To reduce the six-month exclusion period, you should provide us with a copy of any creditable coverage certificates that you have. If you do not have a certificate, but you did have prior health care coverage, we will help you obtain one from your prior plan or carrier. There are also other ways that you can show you have creditable coverage.

All questions about the pre-existing condition exclusion and creditable coverage should be directed to the Customer Service telephone number listed on your member ID card.

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SM7373 8/09

*If your health plan is not subject to California state law, the length of the pre-existing condition exclusion may be up to 12 months (or up to 18 months if you are a late enrollee). Also, the maximum allowable break in coverage may be no more than 63 days in all situations.

Arbitration Agreement

If your coverage is under a private employer plan governed by the Employee Retirement Income Security Act of 1974 (ERISA), certain disputes may not be subject to the following arbitration provisions:

Any and all disputes between you (and/or any enrolled family member) and Anthem Blue Cross Life and Health Insurance Company, including claims for medical malpractice, must be resolved by binding arbitration, if the amount in dispute exceeds the jurisdictional limit of the Small Claims Court, and not by lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. Under this coverage, both the member and Anthem Blue Cross Life and Health are giving up the right to have any dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Anthem Blue Cross Life and Health and the member also agree to give up any right to pursue on a class basis any claim or controversy against the other. For more information regarding binding arbitration, please refer to your Certificate.

If you are enrolled in an employer-sponsored benefit plan that is subject to ERISA (Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1001, et seq.) any dispute involving an adverse benefit determination for a health claim may not be subject to mandatory binding arbitration. However, any dispute with respect to an adverse benefit determination for a health claim may be submitted to voluntary binding arbitration after the ERISA claim appeal process is completed.

Privacy Practice

Anthem Blue Cross Life and Health Insurance Company is fully committed to protecting our members' 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. You may obtain our complete *Notice of Privacy Practices* from our website at anthem.com/ca or by calling the Customer Service number listed on your member ID card.

Summary of Benefits





Language Assistance Notice

Effective January 1, 2009

IMPORTANT: An interpreter can be provided for you to communicate with your doctor or health plan at no cost. To get an interpreter or to ask about written information in your language, please contact your group administrator.

IMPORTANTE: Se le puede brindar sin costo los servicios de un intérprete para que pueda comunicarse con su médico o plan de salud. Para obtener un intérprete o para solicitar información escrita en su idioma, comuníquese con el administrador de su grupo. (Spanish)

重要提示: 您與您的醫生或保健計畫交談時，可獲得免費口譯服務。如欲請翻譯員提供口譯，或欲查詢中文書面資料，請聯絡您的團體行政人員。(Cantonese or Mandarin)

중요: 의사 또는 건강보험사와의 의사소통을 위하여 통역사를 무료로 이용하실 수 있습니다. 통역이나 한국어로 번역된 정보를 원하시면 그룹 담당자에게 요청하시기 바랍니다. (Korean)

MAHALAGA: Mai-alok ang tagapagsalin sa iyo nang libre upang makipag-usap ka sa iyong doktor o planong pangkalusugan. Upang kumuha ng tagapagsalin o magtanong tungkol sa nakasulat na impormasyon sa iyong lengguahe, paki-usap ang tagapangasiwa ng iyong pangkat. (Tagalog)

CHÚ Ý QUAN TRỌNG: Quý vị có thể được thông dịch viên giúp đỡ miễn phí khi quý vị cần tiếp xúc với bác sĩ hoặc nhân viên trong chương trình bảo hiểm sức khỏe của quý vị. Để được thông dịch viên giúp đỡ hoặc được cấp thông tin, văn bản chuyển ngữ sang ngôn ngữ của quý vị, xin quý vị vui lòng liên lạc ban quản trị chương trình bảo hiểm. (Vietnamese)



In addition to dollar and percentage copays, insured persons are responsible for deductibles, as described below. Please review the deductible information to know if a deductible applies to a specific covered service. Certain Covered Services have maximum visit and/or day limits per year. The number of visits and/or days allowed for these services will begin accumulating on the first visit and/or day, regardless of whether your Deductible has been met. Insured persons are also responsible for all costs over the plan maximums. Plan maximums and other important information appear in *italics*. Benefits are subject to all terms, conditions, limitations, and exclusions of the Policy.

Explanation of Covered Expense

Plan payments are based on covered expense, which is the lesser of the charges billed by the provider or the following:

PPO Providers—PPO negotiated rates. Insured persons are not responsible for the difference between the provider’s usual charges & the negotiated amount.

Non-PPO Providers & Other Health Care Providers (*includes those not represented in the PPO provider network*)—The customary & reasonable charge for professional services or the reasonable charge for institutional services.

When using Non-PPO and Other Health Care Providers, insured persons are responsible for any difference between the covered expense & actual charges, as well as any deductible & percentage copay.

Calendar year deductible for all providers	\$250/insured person maximum of three separate deductibles/family
Deductible for non-PPO hospital	\$500/admission (<i>waived for emergency admission</i>)
Deductible for hospital if utilization review not obtained	\$500/admission (<i>waived for emergency admission</i>)
Deductible for emergency room services	\$100/visit (<i>waived if admitted directly from ER</i>)

Annual Out-of-Pocket Maximums

PPO & Other Health Care Providers \$2,000/insured person/year; \$4,000/family/year
 Non-PPO Providers \$6,000/insured person/year; \$12,000/family/year

The following do not apply to out-of-pocket maximums: deductibles listed above; non-covered expense. After an insured person reaches the out-of-pocket maximum, the insured person remains responsible for deductibles listed above; amounts related to a transplant unrelated donor search and, for non-PPO providers & other health care providers, costs in excess of the covered expense.

Lifetime Maximum	\$5,000,000/insured person
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Covered Services	PPO: Per Insured Person Copay	Non-PPO: Per Insured Person Copay
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Hospital Medical Services (<i>subject to utilization review for inpatient services; waived for emergency admission</i>)		
➤ Semi-private room, meals & special diets, & ancillary services	10%	30%
➤ Outpatient medical care, surgical services & supplies (<i>hospital care other than emergency room care</i>)	10%	30%
Ambulatory Surgical Centers		
➤ Outpatient surgery, services & supplies	10% ¹	30% ¹ (<i>benefit limited to \$350/day</i>)
Hemodialysis		
➤ Outpatient hemodialysis services & supplies	10% ¹	30% ¹ (<i>benefit limited to \$350/day</i>)
Skilled Nursing Facility (<i>subject to utilization review</i>)		
➤ Semi-private room, services & supplies (<i>limited to 100 days/calendar year including residential treatment center</i>)	10% ¹	30% ¹
Hospice Care		
➤ Inpatient or outpatient services for insured persons (<i>limited to combined maximum of \$5,000/lifetime for all inpatient and home hospice service</i>)		20% ²
Home Health Care		
➤ Services & supplies from a home health agency (<i>limited to combined maximum of \$110/day & up to 100 visits/calendar year, one visit by a home health aide equals four hours or less; not covered while insured person receives hospice care</i>)	10% ¹	30% ¹

¹ These providers may not be represented in the PPO network in the state where the insured person receives services. If such provider is not available in the service area, the insured person’s copay is the same as for PPO. All copays are in addition to applicable deductibles.

² These providers may not be represented in the PPO network in the state where an insured person receives services. If such provider is not available in the service area, the insured person’s copay is 20%. If such provider is available in the service area and the insured person receives services from a PPO provider, the insured person’s

copay is 10%. However, if the insured person chooses to receive services from a non-PPO provider when such provider is available in the service area, the insured person's copay is 30%. All copays are in addition to applicable deductibles.

Covered Services	PPO: Per Insured Person Copay	Non-PPO: Per Insured Person Copay
Infusion Therapy <i>(subject to utilization review)</i>		
➤ Includes medication, ancillary services & supplies; caregiver training & visits by provider to monitor therapy; durable medical equipment; lab services	10% ¹	30% ¹ <i>(benefit limited to \$600/day)</i>
Physician Medical Services		
➤ Office & home visits	\$15/visit ² <i>(deductible waived)</i>	30%
➤ Hospital & skilled nursing facility visits	10%	30%
➤ Surgeon & surgical assistant; anesthesiologist or anesthetist	10%	30%
Diagnostic X-ray & Lab		
➤ MRI, CT scan, PET scan & nuclear cardiac scan <i>(subject to utilization review)</i>	10% ¹	30% ¹
➤ Other diagnostic x-ray & lab	10% ¹	30% ¹
Well Baby & Well-Child Care for Dependent Children		
➤ Routine physical exams <i>(birth through age six)</i>	\$15/exam <i>(deductible waived)</i>	30% <i>(benefit limited to \$20/exam)</i>
➤ Immunizations <i>(birth through age six)</i>	No copay <i>(deductible waived)</i>	30% <i>(benefit limited to \$12/immunization)</i>
Physical Exams for Insured Persons Ages Seven & Older		
➤ Routine physical exams, immunizations, diagnostic X-ray & lab for routine physical exam	\$15/exam <i>(deductible waived)</i>	Not covered
Adult Preventive Services <i>(including mammograms, Pap smears, prostate cancer screenings & colorectal cancer screenings)</i>	10% <i>(deductible waived)</i>	30% <i>(deductible waived)</i>
Physical Therapy, Physical Medicine & Occupational Therapy, including Chiropractic Services <i>(limited to 24 visits/calendar year; additional visits may be authorized)</i>	10%	30% <i>(benefit limited to \$25/visit)</i>
Speech Therapy		
➤ Outpatient speech therapy following injury or organic disease	10%	30%
Acupuncture		
➤ Services for the treatment of disease, illness or injury <i>(limited to \$30/visit & 12 visits/calendar year)</i>	10% ³	30% ³
Temporomandibular Joint Disorders		
➤ Splint therapy & surgical treatment	10%	30%
Pregnancy & Maternity Care		
➤ Physician office visits	\$15/visit ² <i>(deductible waived)</i>	30%
➤ Prescription drug for elective abortion <i>(mifepristone)</i> Normal delivery, cesarean section, complications of pregnancy & abortion <i>(newborn routine nursery care covered when natural mother is insured employee or spouse/domestic partner)</i>	10%	30%
➤ Inpatient physician services	10%	30%
➤ Hospital & ancillary services	10%	30%
Organ & Tissue Transplants <i>(subject to utilization review)</i>		
➤ Inpatient services provided in connection with non-investigative organ or tissue transplants	10%	30%
➤ Unrelated donor search, limited to \$30,000 per transplant		

¹ These providers may not be represented in the PPO network in the state where the insured person receives services. If such provider is not available in the service area, the insured person's copay is the same as for PPO. All copays are in addition to applicable deductibles.

² The dollar copay applies only to the visit itself. An additional 10% copay applies for any services performed in office (i.e., x-ray, lab, surgery), after any applicable deductible.

³ Acupuncture services can be performed by a certified acupuncturist (C.A.), a doctor of medicine (M.D.), a doctor of osteopathy (D.O.), a podiatrist (D.P.M.), or a dentist (D.D.S.).

Covered Services	PPO: Per Insured Person Copay	Non-PPO: Per Insured Person Copay
Diabetes Education Programs <i>(requires physician supervision)</i>		
➤ Teach insured persons & their families about the disease process, the daily management of diabetic therapy & self-management training	\$15/visit <i>(deductible waived)</i>	30%
Prosthetic Devices		
➤ Coverage for breast prostheses; prosthetic devices to restore a method of speaking; surgical implants; artificial limbs or eyes; the first pair of contact lenses or eyeglasses when required as a result of eye surgery; & therapeutic shoes & inserts for insured persons with diabetes	10%	30%
Durable Medical Equipment		
➤ Rental or purchase of DME including hearing aids, dialysis equipment & supplies <i>(limited to \$5,000/calendar year)</i>	10% ¹	30% ¹
Related Outpatient Medical Services & Supplies		
➤ Ground or air ambulance transportation, services & disposable supplies		20% ²
➤ Blood transfusions, blood processing & the cost of unreplaced blood & blood products		20% ²
➤ Autologous blood <i>(self-donated blood collection, testing, processing & storage for planned surgery)</i>		20% ²
Emergency Care		
➤ Emergency room services & supplies <i>(\$100 deductible waived if admitted)</i>	10%	10%
➤ Inpatient hospital services & supplies	10%	10% for initial treatment; 30% after initial treatment
➤ Physician services	10%	10%
Mental or Nervous Disorders and Substance Abuse		
➤ Inpatient hospital & outpatient day treatment center <i>(subject to utilization review; waived for emergency admissions)</i>	10%	30%
➤ Inpatient physician visits	10%	30%
➤ Outpatient physician visits <i>(pre-service review required after the 12th visit)</i>	\$15/visit ³ <i>(deductible waived)</i>	30%

¹ These providers may not be represented in the PPO network in the state where the insured person receives services. If such provider is not available in the service area, the insured person's copay is the same as for PPO. All copays are in addition to applicable deductibles.

² These providers may not be represented in the PPO network in the state where an insured person receives services. If such provider is not available in the service area, the insured person's copay is 20%. If such provider is available in the service area and the insured person receives services from a PPO provider, the insured person's copay is 10%. However, if the insured person chooses to receive services from a non-PPO provider when such provider is available in the service area, the insured person's copay is 30%. All copays are in addition to applicable deductibles.

³ The dollar copay applies only to the visit itself. An additional 10% copay applies for any services performed in office (i.e., x-ray, lab, surgery), after any applicable deductible.

In addition to the benefits described above, coverage may include additional benefits, depending upon the insured person's home state. The benefits provided in this summary are subject to federal and California laws. There are some states that require more generous benefits be provided to their residents, even if the master policy was not issued in their state. If the insured person's state has such requirements, we will adjust the benefits to meet the requirements.

This Summary of Benefits is a brief review of benefits. Once enrolled, insured persons will receive a Certificate of Insurance, which explains the exclusions and limitations, as well as the full range of covered services of the plan, in detail.

BC Premier ET Plan—Exclusions and Limitations

Not Medically Necessary. Services or supplies that are not medically necessary, as defined.

Experimental or Investigative. Any experimental or investigative procedure or medication. But, if insured person is denied benefits because it is determined that the requested treatment is experimental or investigative, the insured person may request an independent medical review, as described in the Certificate.

Outside the United States. Services or supplies furnished and billed by a provider outside the United States, unless such services or supplies are furnished in connection with an emergency.

Crime or Nuclear Energy. Conditions that result from (1) the insured person's commission of or attempt to commit a felony, as long as any injuries are not a result of a medical condition or an act of domestic violence; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available for the treatment of illness or injury arising from the release of nuclear energy.

Excess Amounts. Any amounts in excess of covered expense or the lifetime maximum.

Work-Related. Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, whether or not the insured person claims those benefits. If there is a dispute of substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers' compensation, we will provide the benefits of this plan for such conditions, subject to our right of recovery, as specified as covered in the Certificate.

Government Treatment. Any services the insured person actually received that were provided by a local, state or federal government agency, except when payment under this plan is expressly required by federal or state law. We will not cover payment for these services if the insured person is not required to pay for them or they are given to the insured person for free.

Services of Relatives. Professional services received from a person living in the insured person's home or who is related to the insured person by blood or marriage, except as specified as covered in the Certificate.

Voluntary Payment. Services for which the insured person is not legally obligated to pay. Services for which the insured person is not charged. Services for which no charge is made in the absence of insurance coverage, except services received at a non-governmental charitable research hospital. Such a hospital must meet the following guidelines:

1. it must be internationally known as being devoted mainly to medical research;
2. at least 10% of its yearly budget must be spent on research not directly related to patient care;
3. at least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;
4. it must accept patients who are unable to pay; and
5. two-thirds of its patients must have conditions directly related to the hospital's research.

Not Specifically Listed. Services not specifically listed in the plan as covered services.

Private Contracts. Services or supplies provided pursuant to a private contract between the insured person and a provider, for which reimbursement under Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

Inpatient Diagnostic Tests. Inpatient room and board charges in connection with a hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.

Mental or Nervous Disorders. Academic or educational testing, counseling, and remediation. Mental or nervous disorders or substance abuse, including rehabilitative care in relation to these conditions, except as specified as covered in the Certificate.

Nicotine Use. Smoking cessation programs or treatment of nicotine or tobacco use. Smoking cessation drugs.

Orthodontia. Braces and other orthodontic appliances or services.

Dental Services or Supplies. Dental plates, bridges, crowns, caps or other dental prostheses, dental implants, dental services, extraction of teeth, or treatment to the teeth or gums, or treatment to or for any disorders for the jaw joint, except as specified as covered in the Certificate. Cosmetic dental surgery or other dental services for beautification.

Hearing Aids or Tests. Hearing aids, except as specified as covered in the Certificate. Routine hearing tests.

Optometric Services or Supplies. Optometric services, eye exercises including orthoptics, routine eye exams and routine eye refractions. Eyeglasses or contact lenses, except as specified as covered in the Certificate.

Outpatient Occupational Therapy. Outpatient occupational therapy, except by a home health agency, hospice, or home infusion therapy provider, as specified as covered in the Certificate.

Outpatient Speech Therapy. Outpatient speech therapy, except as specified as covered in the Certificate.

Cosmetic Surgery. Cosmetic surgery or other services performed solely for beautification or to alter or reshape normal (including aged) structures or tissues of the body to improve appearance. This exclusion does not apply to reconstructive surgery (that is, surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or to create a normal appearance), including surgery performed to restore symmetry following mastectomy. Cosmetic surgery does not become reconstructive surgery because of psychological or psychiatric reasons.

Commercial Weight Loss Programs. Weight loss programs, whether or not they are pursued under medical or physician supervision, unless specifically listed as covered in this plan.

This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

This exclusion does not apply to *medically necessary* treatments for morbid obesity or dietary evaluations and counseling, and behavioral modification programs for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity will be covered only when criteria is met as recommended by our Medical Policy.

Sex Transformation. Procedures or treatments to change characteristics of the body to those of the opposite sex.

Sterilization Reversal.

Infertility Treatment. Any services or supplies furnished in connection with the diagnosis and treatment of infertility, including, but not limited to, diagnostic tests, medication, surgery, artificial insemination, in vitro fertilization, sterilization reversal, and gamete intrafallopian transfer.

Surrogate Mother Services. For any services or supplies provided to a person not covered under the plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

Orthopedic Supplies. Orthopedic supplies, orthopedic shoes (other than shoes joined to braces), or non-custom molded and cast shoe inserts, except for therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications as specified as covered in the Certificate.

Air Conditioners. Air purifiers, air conditioners or humidifiers.

Custodial Care or Rest Cures. Inpatient room and board charges in connection with a hospital stay primarily for environmental change or physical therapy. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a skilled nursing facility or custodial care or rest cures, except as specified as covered in the Certificate.

Chronic Pain. Treatment of chronic pain, except as specified as covered in the Certificate.

Health Club Memberships. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment or facilities used for developing or maintaining physical fitness, even if ordered by a *physician*. This exclusion also applies to health spas.

Personal Items. Any supplies for comfort, hygiene or beautification.

Education or Counseling. Educational services or nutritional counseling, except as specified as covered in the Certificate. This exclusion does not apply to counseling for the treatment of anorexia nervosa or bulimia nervosa.

Food or Dietary Supplements. Nutritional and/or dietary supplements, except as provided in this plan or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist.

Telephone and Facsimile Machine Consultations. Consultations provided by telephone or facsimile machine.

Routine Exams or Tests. Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority, except as specified as covered in the Certificate.

Acupuncture. Acupuncture treatment, except as specified as covered in the Certificate. Acupressure or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatomes or acupuncture points.

Eye Surgery for Refractive Defects. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery.

Physical Therapy or Physical Medicine. Services of a physician for physical therapy or physical medicine, except when provided during a covered inpatient confinement or as specified as covered in the Certificate.

Outpatient Prescription Drugs and Medications. Outpatient prescription drugs, medications and insulin except as specified as covered in the certificate. Non-prescription, over-the-counter patent or proprietary drugs or medicines. Cosmetics, health or beauty aids.

Contraceptive Devices. Contraceptive devices prescribed for birth control except as specified as covered in the Certificate.

Diabetic Supplies. Prescription and non-prescription diabetic supplies except as specified as covered in the Certificate.

Private Duty Nursing. Inpatient or outpatient services of a private duty nurse.

Lifestyle Programs. Programs to alter one's lifestyle which may include but are not limited to diet, exercise, imagery or nutrition. This exclusion will not apply to cardiac rehabilitation programs approved by us.

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Pre-Existing Conditions — No payment will be made for services or supplies for the treatment of a pre-existing condition during a period of six months following either: (a) the insured person's effective date or (b) the first day of any waiting period required by the group, whichever is earlier. However, this limitation does not apply to a child born to or newly adopted by an enrolled employee or spouse/domestic partner, or to conditions of pregnancy. Also if an insured person was covered under creditable coverage, as outlined in the insured person's Certificate, the time spent under the creditable coverage will be used to satisfy, or partially satisfy, the six month period.

Third Party Liability — Anthem Blue Cross Life and Health Insurance Company is entitled to reimbursement of benefits paid if the insured person recovers damages from a legally liable third party.

Coordination Of Benefits — The benefits of this plan may be reduced if the insured person has any other group health or dental coverage so that the services received from all group coverages do not exceed 100% of the covered expense.

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San Bernardino Community College District 5/15/30 20% Self-Injectable – Modified Prescription Drug Benefits

PLEASE NOTE: *The following represents a summary only. Please refer to your Evidence of Coverage (“EOC”) which explains your plan’s Exclusions and Limitations as well as the full range of your covered services in detail.*

At Anthem Blue Cross, we know that prescription drugs are the fastest-rising item of your total health care benefits cost. Reasons for the spiraling costs of prescription drugs are varied: a general increase of prescription medication use, an aging population, research and development of new medications and the expense of direct to consumer advertising. With prescription drug costs increasing at twice the rate of medical care, we developed ways to contain costs so your copays remain affordable, while maintaining your access to safe, effective prescription drugs. Our Prescription Drug Program provides you with choice, flexibility, affordability and access to an extensive network of retail pharmacies.

Getting a Prescription Filled at a Participating Pharmacy

To get a prescription filled, you need only take your prescription to a participating pharmacy and present your member ID card. The amount you pay for a covered prescription – your copay – will be determined by whether the drug is a brand-name or generic medication and whether it is a formulary or non-formulary medication.

A generic drug contains the same effective ingredients, meets the same standards of purity as its brand-name counterpart and typically costs less. In many situations, you have a choice of filling your prescription with a generic medication or a brand-name medication.

The formulary is a list of approximately 600 recommended brand and generic medications. These medications have undergone extensive review for therapeutic value for a particular medical condition, safety and cost. Copies of our formulary are furnished to your providers and are available online at anthem.com/ca under the Pharmacy section. You or your provider may also contact our Pharmacy Customer Service at (800) 700-2541.

The following chart summarizes the relation between drug type and your copay amount at a participating pharmacy:

Drug Type	Copay Amount
Generic	\$5.00
Brand name formulary	\$15.00 ¹
Brand name non-formulary	\$30.00 ¹

Finding a Participating Pharmacy

Because our huge pharmacy network includes major drugstore chains plus a wide variety of independent pharmacies, it is easy for you to find a participating pharmacy. You can also find a participating pharmacy by going to our Web site at anthem.com/ca.

An Extensive Network

Besides saving you money, our extensive network of pharmacies offers you easy accessibility.

- In California there are over 5,100 retail pharmacies. This accounts for nearly 95% of retail pharmacies in the state, including all major chains.
- Nationwide there are more than 61,000 chain and independent pharmacies.

Using a Participating Pharmacy

You can substantially control the cost of your prescription drugs by using our extensive network of participating pharmacies. Participating pharmacies have agreed to charge a discounted price or “negotiated rate” and pass along this savings to you.

Using a Non-Participating Pharmacy

If you choose to fill your prescription at a non-participating pharmacy, your costs will increase. You will likely need to pay for the entire amount of the prescription and then submit a prescription drug claim form for reimbursement. The pharmacist must sign and complete the appropriate section of the claim form to ensure proper processing of the claim for reimbursement.

Members that submit claims from non-participating pharmacies are reimbursed based on a **limited fee schedule**. The fee schedule may be considerably less than the cost of the medication. You are responsible for paying any difference.

The following chart illustrates potential increased out-of-pocket expenses for going to a non-participating pharmacy:

	Out-of-pocket costs using a participating pharmacy	Out-of-pocket costs using a non-participating pharmacy
Pharmacy's normal charge for brand-name formulary drug	\$50.00	\$50.00
You are responsible for:	\$15.00 copay	\$15 copay plus 50% of the limited fee schedule plus any amounts exceeding the fee schedule
Total out-of-pocket expenses	\$15.00	Expense varies based on the cost of the medication

You may obtain a prescription drug claim form by calling Pharmacy Customer Service at the toll-free number printed on your member ID card or by going to our Web site at anthem.com/ca.

Submitting a Claim Form

Check to see that all sections of the claim form are completed and mail to:

Anthem Blue Cross Prescription Drug Program
Attn: Anthem Blue Cross
P.O. Box 4165
Woodland Hills, CA 91365-4165

Mail Service Prescription Drug Program

If you take a prescription drug on a regular basis, you may want to take advantage of our mail service program. Ordering your medications by mail is convenient, saves time and depending on your plan design, may even save you money. Besides enjoying the convenience of home delivery, you will also receive a greater supply of medications. To fill a prescription through the mail, simply complete the Mail Service Prescription form. You may obtain the form by calling Customer Service, at the toll-free number listed on your ID card or by going to our Web site at anthem.com/ca.

Once you complete the form, simply mail it with your copay and prescription in the envelope attached to the Mail Service brochure.

Please note that not all medications are available through the Mail Service Program. Specialty pharmacy drugs are not available through the mail service program, see Specialty Pharmacy Program below.

Out-Of-State Prescription Benefits

Our national network of participating pharmacies is available to members when outside California. To find a participating pharmacy, a member can check our Web site or call the toll-free number printed on the ID card. When using a non-participating pharmacy outside of California, the member will follow the same procedures for using a non-participating pharmacy in California as outlined above.

Additional Features That are Part of your Plan

Prior authorization as the term implies, is similar to prior authorization for medical services. Prior authorization applies to a select pool of medications that are often a second line of therapy. To receive prior authorization, a drug must meet specific criteria. The criteria are based, among other things, on FDA-approved drug indications, targeted populations and the current availability of effective drug therapies. Prior authorization drugs are not covered unless you receive a prior approval from Anthem Blue Cross.

We distribute instructions on how to obtain prior authorization to physicians and pharmacies so that you may obtain prior authorization for required medications. You may call Pharmacy Customer Service, at the toll-free number printed on your member ID card, to receive a prior authorization form and/or list of medications requiring prior authorization.

Supply limits are the proper FDA recommendations for prescription medication dosage coupled with our determination of specific quantity supply limits to prescription medications. Although our standard pharmacy plans offer a 30-day supply for medications at a retail pharmacy, the supply limit can vary based on the medication, dosage and usage prescribed by your physician. For example, the supply limit for antibiotics used to treat an infection (e.g., 14 pills to be taken twice a day for one week) is different than blood pressure medication taken on a routine basis (e.g., 120 pills to be taken twice a day for 60 days). By adhering to specified supply limits, members are assured of receiving the appropriate amount of medication.

Specialty Pharmacy Program

Specialty medications are usually dispensed as an injectable drug, but may be available in other forms, such as a pill or inhalant. They are used to treat complex conditions. Prescriptions for a specialty pharmacy drug are covered only when ordered through the specialty pharmacy program unless you are given an exception from the specialty drug program (see your EOC for details). The specialty pharmacy program will deliver your medication to you by mail or common carrier (you cannot pick up your medication).

You may have to pay the full cost of a specialty pharmacy drug if it is not obtained from the specialty pharmacy program.

Specialty drugs are limited to a 30-day supply for each fill.

Programs for Member's Special Health Needs

We recognize that some of our members have unique health care needs requiring special attention. That's why we developed programs exclusively for them. Our additional medical management programs work in synergy with our pharmacy drug program to help members better manage their health care on an ongoing basis.

Diabetic members can receive **free glucometers** so that they can effectively and conveniently monitor their glucose levels.

Seniors can better monitor their chronic diseases and multiple medications through our **seniors-at-risk program**. This program reduces the possibility of toxic drug interactions, and curtails distribution of medications that may adversely affect the senior's chronic condition.

Asthmatic members and their families can take advantage of our program to better control the frequency and severity of the disease.

Members who take multiple prescription medications can take advantage of our pharmacy utilization management programs that encourage the safe, effective distribution of prescription medications. We have a program that protects the welfare of members with multiple prescription medications by carefully monitoring their prescription therapy to help reduce the danger of toxic drug interaction.

For additional information regarding your prescription drug benefits, please call Pharmacy Customer Service at the toll-free number printed on your member ID card.

Covered Services (outpatient prescriptions only)	Per Member Copay for Each Prescription or Refill
Retail Participating Pharmacies	
➤ Generic drugs	\$5
➤ Brand name formulary drugs ¹	\$15
➤ Brand name non-formulary drugs ¹	\$30
➤ Compound drugs ¹	\$30
➤ Self-administered injectable drugs, except insulin	20% of prescription drug covered expenses (maximum \$150 copay)
Mail Service	
➤ Generic drugs	\$5
➤ Brand name formulary drugs ¹	\$30
➤ Brand name non-formulary drugs ¹	\$60
➤ Self-administered injectable drugs, except insulin	20% of prescription drug covered expenses (maximum \$300 copay)
Specialty Pharmacy Drugs (may only be obtained through the specialty pharmacy program)	
➤ Generic drugs	\$5
➤ Brand name drugs ¹	\$15
➤ Brand name non-formulary drugs ¹	\$30
➤ Self-administered injectable drugs, except insulin	20% of prescription drug covered expenses (maximum \$150 copay)
Non-participating Pharmacies (compound drugs & specialty pharmacy drugs not covered at retail participating pharmacies)	Member pays the above retail participating pharmacies copay plus: 50% of the remaining prescription drug covered expense & costs in excess of the maximum amount allowed
Supply Limits²	
➤ Retail Pharmacy (participating and non-participating)	30-day supply; 60-day supply for federally classified Schedule II attention deficit disorder drugs that require a triplicate prescription form, but require a double copay; 6 tablets or units/30-day period for impotence and/or sexual dysfunction drugs (available only at retail pharmacies)
➤ Mail Service	90-day supply
➤ Specialty Pharmacy	30-day supply

¹ **Mandatory Generic Substitution** If a member requests a formulary or non-formulary brand name drug when a generic drug substitution exists, the member pays the generic drug copay plus the difference in cost between the negotiated rate for the generic drug and the brand name drug dispensed, but not more than 50% of our cost of the prescription drug. Mandatory generic substitution does not apply when the physician has specified "dispense as written" (DAW) or when it has been determined that the brand name drug (formulary or non-formulary) is medically necessary for the member. In such case, the applicable copay for the dispensed drug will apply.

² Supply limits for certain drugs may be different. Please refer to the Evidence of Coverage and Disclosure form (EOC) for complete information.

The Prescription Drug Benefit covers the following:

- Outpatient prescription drugs and medications which the law restricts to sale by prescription. Formulas prescribed by a physician for the treatment of phenylketonuria. These formulas are subject to the copay for brand name drugs.
- Insulin
- Syringes when dispensed for use with insulin and other self-injectable drugs or medications
- Prescription oral contraceptives; contraceptive diaphragms. Contraceptive diaphragms are limited to one per year and are subject to the brand name copay.
- Injectable drugs which are self-administered by the subcutaneous route (under the skin) by the patient or family member. Drugs that have Food and Drug Administration (FDA) labeling for self-administration
- All compound prescription drugs that contain at least one covered prescription ingredient
- Diabetic supplies (i.e., test strips and lancets)
- Prescription drugs for treatment of impotence and/or sexual dysfunction are limited to organic (non-psychological) causes.
- Inhaler spacers and peak flow meters for the treatment of pediatric asthma. These items are subject to the copay for brand name drugs.
- Certain over-the-counter drugs approved by the Pharmacy and Therapeutics Committee to be included in the prescription drug formulary.

Prescription drug copays are separate from the medical copays of the medical plan and are not applied toward the Annual Out-of-Pocket Maximums under the Medical Plan.

Prescription Drug Exclusions & Limitations

Immunizing agents, biological sera, blood, blood products or blood plasma

Hypodermic syringes &/or needles, except when dispensed for use with insulin & other self-injectable drugs or medications

Drugs & medications used to induce spontaneous & non-spontaneous abortions

Drugs & medications dispensed or administered in an outpatient setting, including outpatient hospital facilities and physicians' offices

Professional charges in connection with administering, injecting or dispensing drugs

Drugs & medications that may be obtained without a physician's written prescription, except insulin or niacin for cholesterol lowering and certain over-the-counter drugs approved by the Pharmacy and Therapeutics Committee to be included in the prescription drug formulary.

Drugs & medications dispensed by or while confined in a hospital, skilled nursing facility, rest home, sanatorium, convalescent hospital or similar facility

Durable medical equipment, devices, appliances & supplies, even if prescribed by a physician, except contraceptive diaphragms, as specified as covered in the EOC

Services or supplies for which the member is not charged

Oxygen

Cosmetics & health or beauty aids.

Drugs labeled "Caution, Limited by Federal Law to Investigational Use," or Non-FDA approved investigational drugs. Any drugs or medications prescribed for experimental indications

Any expense for a drug or medication incurred in excess of (a) the drug limited fee schedule for drugs dispensed by non-participating pharmacies; or (b) the prescription drug negotiated rate for drugs dispensed by participating pharmacies or through the mail service program

Drugs which have not been approved for general use by the State of California Department of Health Services or the Food and Drug Administration. This does not apply to drugs that are medically necessary for a covered condition.

Drugs to eliminate or reduce dependency on, or addiction to, tobacco and tobacco products.

This does not apply to medically necessary drugs that the member can only get with a prescription under state and federal law.

Drugs used primarily for cosmetic purposes (e.g., Retin-A for wrinkles). However, this will not apply to the use of this type of drug for medically necessary treatment of a medical condition other than one that is cosmetic.

Drugs used primarily to treat infertility (including, but not limited to, Clomid, Pergonal and Metrodin), unless medically necessary for another covered condition.

Anorexiants and drugs used for weight loss, except when used to treat morbid obesity (e.g., diet pills & appetite suppressants)

Drugs obtained outside the U.S., unless they are furnished in connection with urgent care or an emergency.

Allergy desensitization products or allergy serum

Infusion drugs, except drugs that are self-administered subcutaneously

Herbal supplements, nutritional and dietary supplements, except for formulas for the treatment of phenylketonuria.

Prescription drugs with a non-prescription (over-the-counter) chemical and dose equivalent except insulin. This does not apply if an over-the-counter equivalent was tried and was in effective.

Compound medications unless:

- There is at least one component in it that is a prescription drug; and
- It is obtained from a participating pharmacy. **Member will have to pay the full cost of the compound medications if member obtains drug at a non-participating pharmacy.**

Specialty pharmacy drugs that must be obtained from the specialty pharmacy program, but, which are obtained from a retail pharmacy are not covered by this plan. **Member will have to pay the full cost of the specialty pharmacy drugs obtained from a retail pharmacy that member should have obtained from the specialty pharmacy program.**

Third Party Liability

Anthem Blue Cross is entitled to reimbursement of benefits paid if the member recovers damages from a legally liable third party.

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Additional Benefits



Online Services

anthem.com/ca



Anthem Blue Cross strives to provide more than affordable, high-quality coverage. We want to add value to your total health care experience by making health care information easily accessible, and offering online resources to help you make better-informed decisions.

The anthem.com/ca website was designed with these needs in mind and includes lots of links to the areas that matter most to you.

The site contains two sections:

1. **MyAnthem**, a personalized member password-protected area.
2. A general **Visitors** area for anyone who wants to learn about our health care plans and member services.

With a simple click of the mouse, you can be instantly connected to information about providers and services available exclusively to Anthem Blue Cross members.

MyAnthem

Need information quickly? Confidentially? And conveniently? Then, visit Anthem Blue Cross' secure **MemberAccess** site. Here, you will find electronic versions of your health care documents and other valuable resources. The site includes the following features and much more:

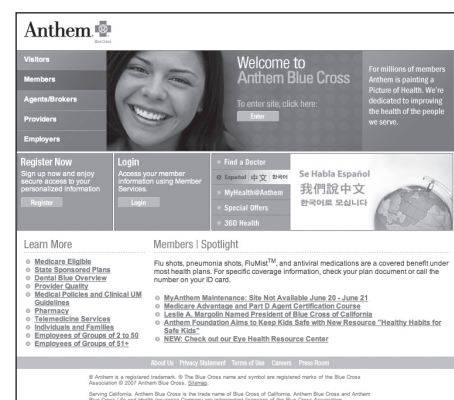
- **View Claims (medical, dental):** Review the status of current and paid claims.
- **View your Evidence of Coverage/Certificate of Insurance:** View, save electronically and print hard copies of your health benefits contract summary.
- **Enroll in Paperless EOBs:** Sign up to receive e-mail notification when a claim is processed, so you can review your Explanation of Benefits (EOB) online and then print it.
- **View Contract Information:** View your current medical plan and any other benefits covering you and your enrolled dependents.

- **WebMD:** Access your personalized **WebMD**® tools and health information. Receive comprehensive health-risk assessments, checkup and text reminders, and other customized resources.
- **Search Hospital and Pharmacy Information:** Access an online resource that allows you to research procedures and screen hospitals based on your personal criteria.
- **Request ID Card:** Electronically request a new ID card for you or a family member.
- **Grievance Form:** File an online grievance, print a hard copy for mailing, or learn more about the Anthem Blue Cross grievance process and how to complete a grievance form.
- **Contact Us:** Electronically communicate with Customer Service about benefit issues, questions or concerns.

How do you get to MyAnthem?

To log on, just follow these easy steps:

1. Go to anthem.com/ca and click on **Members**.
2. Select **Login** to access your member information.
3. Next, enter your user ID and password or choose **Register Now**. After completing the registration process, any member over 18 may create a unique user ID and password. Members of family policies may restrict the viewing of their information by other members on their policy by clicking the **Restricted View** option.
4. Once your unique user ID has been accepted, you may access the secure site.



Your Direct Connection to More Information

You can also surf our website for more general, nonconfidential information and tools, including:

- **Find a Doctor (in California and out of state):** Find a physician, medical group, dentist or pharmacy near you through our *Online Provider Directory*.
- **Download Forms:** Download and print important forms, including *Member Claim, Mail-Order Prescription Drug, Flexible Spending Account, Medicare Part D Prescription Drug Claim* and many others.
- **Over the Counter:** Access the PrecisionRx OTC Store, where you can get over-the-counter products delivered to your door.
- **Value-Added Programs:** Find health care resources, information and special discounts on wellness products and services through SpecialOffersSM and other programs.
- **Coverage Advisor:** Estimate your annual medical expenses and out-of-pocket costs associated with different health coverage.

To access the general site:

- A. Click on *Members*, located on the top-left corner of the home page.
- B. Since your health care coverage is provided through your employer, select *Employees of Groups of 51 or More* on the left-side navigation bar.
- C. Finally, browse and choose the categories you are interested in.

We work hard to empower you as members and health care consumers.

Get connected to our website and its wealth of resources, and take control today!

The Subimo website is owned and operated by Subimo, LLC, P.O. Box 5335, River Forest, Illinois 60305. Subimo, LLC, is solely responsible for its website and is not affiliated with Anthem Blue Cross or any affiliate of Anthem Blue Cross.

The WebMD website is owned and operated by WebMD Health Corp. WebMD Health is solely responsible for its website and is not affiliated with Anthem Blue Cross or any affiliate of Anthem Blue Cross.

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anthem.com/ca

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MyHealth Record



Organize your medical information and time spent with your doctor.

We know that your health history directly affects your health today. That's why we developed MyHealth Record, giving you the option to store all of your health records – easily and securely – in one convenient spot.

Getting started is easy:

1. Go to anthem.com/ca
2. Log in or register for MemberAccess
3. Click on the 360° Health tab
4. Locate Update MyHealth Record

Tell me more ... How will this help me?

MyHealth Record is a helpful way to record treatment and preventive care services, list doctor's appointments, and keep track of various medications. Maintaining a personal health record helps keep your information organized and makes it easy to access at any time.

MyHealth Record also provides you with a more personalized experience. Patient education, health management programs, health news and tools are all customized based on your personalized health profile, giving you the ability to make more informed decisions about your health.

The enhanced MyHealth Record can also make your medical visits more valuable – because you will have a wealth of knowledge at hand. For example:

- Print out the easy-to-read health summary and share it with your physicians. It may identify an important detail that may not be in your physician's medical record or bring a new physician up-to-date on your medical history.
- Track doctor visits, vaccinations and other wellness services – a great help if you see multiple doctors.
- Stay organized by consolidating your health history into one secure location.
- Improve the availability of essential information at the point of care – critical in case of an emergency.

Health Record Summary for Jane Smith	
Date of Birth:	1/1/1970
Date of Report:	3/3/2006
Your Personal Health Record (PHR) contains information supplied by you and by Anthem Blue Cross. The categories of information supplied by Anthem Blue Cross may vary from your medical record (e.g., pharmacy benefits may not be provided by Anthem Blue Cross). If you have diagnosis, payment or other questions, please contact your treating provider. If you have payment processing questions, please contact Anthem Blue Cross the number on the back of your identification card.	
Personal Information	
Gender:	Female
Blood Type:	AB
Phone:	111-222-3333
Address:	210 Goldenplace Dr. Anaheim, CA 91000
Physician Information	
Type:	Hospital
Name:	John Fritz M.D.
Facility:	ABC Primary Medical Care

How does it work?

When you enroll, we will begin to send medical claims information currently on file to *WebMD* to populate your health record. Anthem Blue Cross will continue to update your health record weekly with information based on your health claims. This will allow us to offer you health information that's customized for you. And it's all at no cost to you.

How do I enroll?

All it takes is a few clicks of the mouse. Go to anthem.com/ca. Register or log in to MemberAccess and click on the "360° Health" tab. Then select the checkbox that says "I agree to allow my health plan to send health claims to WebMD to populate MyHealth Record." Click "Continue," and you're finished. It's that simple.

Will my information be kept private?

Yes, absolutely. We will continue to follow strict privacy and security standards. You can review these privacy policies at anthem.com/ca. There is never an obligation to participate, and you can deactivate the service at any time.

What if I don't want Anthem Blue Cross to send my health claims to WebMD?**Can I still use MyHealth Record?**

Even if you do not choose to have us update MyHealth Record with your health claims information, you can always add your own health information to MyHealth Record. You may enter:

- Dates of immunizations (e.g., flu shots), mammograms, cholesterol test dates
- Dates of surgeries and the names of hospitals where they were performed
- A list of allergies
- Prescription and over-the-counter drugs you are taking
- In-office lab tests (e.g., strep)
- Serious medical conditions

Emergency Health Card

You'll also be able to use this data to create your own Emergency Information Card, a wallet-sized card with a quick overview of important health information such as blood type, allergies, and medical conditions - perfect for times when you or a health care professional needs a quick overview of your medical history. To access your emergency health card, click the 360° Health tab and select "Create MyHealth Record Summary Card."

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The WebMD website is owned and operated by WebMD Health Corp. WebMD Health is solely responsible for its website and is not a liate with Anthem Blue Cross or any a liate of Anthem.

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360° Health® can help you become more engaged in your health and empower you to make the health care decisions that are right for you and your eligible family members. Check out the three categories of 360° Health to see how your health needs can be met:

Health Tools & Resources

Good information is a vital component of good health. For access to health and wellness information and to learn more about health topics, conditions and treatment options, check out anthem.com/ca. Or you can receive our free newsletter in your home or via e-mail and even call to hear confidential recorded messages about hundreds of health topics in English and Spanish.

Our interactive tools and health discounts will help you save money and learn more about keeping yourself and your family healthy. Take advantage of discounts and special offers for smoking cessation, fitness club memberships and weight management programs. Members can also use online tools such as a Body Mass Index (BMI) calculator, diet and exercise tracker and childhood immunization schedule.

Health Guidance

Real life doesn't follow a 9-to-5 schedule. That's why we're here 24 hours a day, 7 days a week to offer health information for the different events in your life, such as a hospital stay, pregnancy or medical question. Contact a registered nurse for answers to your questions and to receive support and encouragement on achieving your health goals.

Health Management

Whether it's 3 p.m. or 3 a.m., wouldn't it be great if you could speak with an experienced nurse about any of your health questions or issues? Now you can!

Anyone living with a chronic disease, such as asthma, diabetes, heart failure, chronic obstructive pulmonary disease (COPD) or coronary artery disease (CAD), does not need additional complications or unanswered questions. We'll work with you, your doctor and other health care providers to help ensure you get the support you need for your condition.

Visit anthem.com/ca to learn more about how 360° Health can help you gain a greater level of health satisfaction.

Go there now: anthem.com/ca > 360° Health

Live life to the fullest – without paying full price.

Save money with SpecialOffers at anthem.com/ca



Saving money is good. Saving money on things that are good for you – that's even better. With SpecialOffers, you can receive discounts on products and services that help promote better health and well-being. And, there's no extra cost to you. SpecialOffers is just one of the perks of being a member. Check out how much you can save:

FAMILY & HOME

American Baby® Magazine – Receive a free subscription to the magazine that takes you through pregnancy and beyond.

Safe Beginnings® – Baby proof your home while saving 15 percent on everything from safety gates to outlet covers. Call 800-598-8911.

SeniorLink – Save 15 percent on elder care advisory services and receive 90 days free service on the HelpLink Emergency Response System to help care for an aging family member. Call 866-797-2336.

Barnes & Noble.com – Browse an online library of selected health and wellness titles, and save 5 percent on your order along with free standard shipping on all orders over \$25. See website for details.

FITNESS & HEALTH

Jenny Craig® – Join Jenny Craig and receive a free 30-day trial, 50 percent off the 6-month program and 20 percent off the Jenny Rewards program. Call 800-96JENNY.

Weight Watchers® – Take \$10 off a 3-month subscription to Weight Watchers Online.

Lindora Lean for Life® – Save 20 percent on weight loss programs and 10 percent on weight loss-related products. Call 800-LINDORA.

GlobalFit™ – Shape up and get fit with membership discounts to local, regional and national fitness clubs.

SelfHelpWorks – Join a SelfHelpWorks online weight loss, smoking cessation, stress or alcohol management program and receive a 30 day free guest pass and a 30 percent discount. Call 877-719-9860.

ChooseHealthy™ – Take the alternative path with discounts on health and wellness products, fitness club memberships, visits to massage therapists, acupuncturists, and more.



Check out more SpecialOffers on the other side.

SpecialOffers at anthem.com/ca

MEDICINE & TREATMENT

drugstore.com™ — Save 5 percent on health, beauty, wellness and personal care products, along with free shipping on orders of \$49 or more.

National Allergy Supply — Save 15 percent on mattress encasings, air filtration products, compressors and other products that can help relieve your allergy, asthma and sinus symptoms. Call 800-522-1448.

VISION, HEARING & DENTAL

HearPO — Save on digital hearing aids, audiology services and testing. Call 888-HEARING.

EyeMed — Save 30 percent on eyeglasses, 25 percent on non-prescription sunglasses and enjoy discounted prices on accessories.

TruVision™ — Pay just \$895 to \$1,895 per eye on LASIK laser vision correction and receive discounts of 15 to 20 percent and free shipping on contact lense orders. Call 877-582-2020.

We've just scratched the surface here.

Visit anthem.com/ca for specific information on all of these offers and more.

Go to anthem.com/ca today!

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

Vendors and offers are subject to change without notice. Anthem Blue Cross does not endorse and is not responsible for the products, services or information provided by the SpecialOffers vendors. Arrangements and discounts were negotiated between each vendor and Anthem Blue Cross for the benefit of our members. All other marks are the property of their respective owners. All of the offers in the SpecialOffers program are continually being evaluated and expanded so the offerings may change. Any additions or changes will be communicated on our website, anthem.com/ca. These arrangements have been made to add value for our members. Value-added products and services are not covered by your health plan benefit. Available discount percentages may change or be discontinued from time to time without notice. Discount is applicable to the items referenced.

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Mail your completed order form, original prescription(s) and payment to: **NextRx, PO Box 746000, Cincinnati, OH 45274-6000.**

If you have multiple prescriptions, include all prescriptions with the order form. You may duplicate the order form as needed.



Section 1: Member Information

Provide policy or cardholder information as found on the health plan or benefit card. Please do not write on the back of form.

Name of Your Health Plan		Identification Number	
[]		[]	
Policy or cardholder last name	First name	Initial	Date of birth (MM/DD/YYYY)
[]	[]	[]	[] / [] / []

Section 2: Shipping Information

Orders ship within seven days of receipt of valid order. Controlled and refrigerated medications cannot ship to a PO box. Schedule II controlled substances require signature on delivery.

New address	Street address			Apartment/suite
<input type="checkbox"/> Y <input type="checkbox"/> N	[]	[]		[]
City	State	ZIP code	Daytime phone # (including area code)	
[]	[]	[]	[]	
E-mail address			Evening phone # (including area code)	
[]			[]	

Section 3: Payment Information

Payment is required before an order will ship. Do not send cash. Make checks and money orders payable to NextRx. There is a \$25 fee for returned checks. Credit cards are charged for the entire order and used for future orders unless a new payment method is specified. Rush shipping does not expedite prescription processing time.

Payment method:	<input type="checkbox"/> Check	<input type="checkbox"/> Visa	<input type="checkbox"/> MasterCard	<input type="checkbox"/> American Express	<input type="checkbox"/> Discover	<input type="checkbox"/> Overnight Shipping (add \$20)
Account number	Expiration date	Signature/date		[]		
[]	[]	[]		[]		
Amount enclosed:	[]	Coupon Code:	[]			
<input type="checkbox"/> Please place prescription(s) on file for later. Do not dispense at this time.						

Section 4: Prescription Information

Federally approved, generic-equivalent medications will be dispensed for brand name medications unless otherwise directed by the patient, physician, or health plan.

Patient last name	First name	Initial	Patient date of birth (MM/DD/YYYY)	Patient gender
[]	[]	[]	[] / [] / []	<input type="checkbox"/> M <input type="checkbox"/> F
Drug allergies (check all that apply): <input type="checkbox"/> Penicillin <input type="checkbox"/> Aspirin <input type="checkbox"/> Codeine <input type="checkbox"/> Sulfa				
<input type="checkbox"/> Other (list all, including over-the-counter medications) []				
Medical history (check all that apply): <input type="checkbox"/> Diabetes <input type="checkbox"/> Glaucoma <input type="checkbox"/> High blood pressure <input type="checkbox"/> Arthritis				
<input type="checkbox"/> Thyroid <input type="checkbox"/> Heart condition <input type="checkbox"/> Asthma <input type="checkbox"/> Other (list all) []				

New prescription: medication name	Doctor last name	Taken before	
[]	[]	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Check corresponding box to place prescription(s) on file for later fill. Do NOT dispense at this time.
[]	[]	<input type="checkbox"/> Y <input type="checkbox"/> N	
[]	[]	<input type="checkbox"/> Y <input type="checkbox"/> N	

Refill orders: Rx refill #	Medication name
[]	[]
[]	[]
[]	[]

Directory



Quick, Easy Ways to Find a Doctor



We offer you quick and easy ways to find participating health care providers – including doctors, hospitals, dentists or pharmacies. To find a provider, simply go to anthem.com/ca, the Anthem Blue Cross website, and use our online provider finder resource. You may also call Customer Service toll-free.

Anthem Blue Cross website

These easy steps will lead you to participating California providers using our online resource. Online provider finder allows you the option of searching for physicians or health care facilities. You can even make your search more specific by choosing a specialty or by entering the name of a physician or facility.

- Go to anthem.com/ca.
- Click on “Find a Doctor,” in the middle of the screen.
- At the next page, click on the link that best describes the type of provider you need: medical with either BlueCard PPO (for Non-CA residents) or local California, dental or vision providers.

At this point, you have a choice of paths:

Existing Member Search

Select this path if you are a current Anthem Blue Cross member with a member identification (ID) card, and are searching for doctors, hospitals or other health care professionals that participate in your current plan. Enter your member ID number in the box provided on the screen.

Your member ID number can be found on your ID card (do not include the three-digit alpha prefix). Click on “Next” at the bottom of each page.

New Member & Visitor Search

Select this path if you are a new member without a member ID card, or are a visitor shopping for an insurance plan and searching for doctors, hospitals or other health care professionals that participate in our various plans. Click on “Next” at the bottom of each page.

If You Travel or Live Outside of California

Members living or traveling outside California can also locate doctors using our online resource.

- Go to anthem.com/ca.
- Click on “Find a Doctor.”
- Then, click on “BlueCard PPO” - you will be linked to the Blue Cross Association website.

Or go ‘directly’ to bluecares.com the Blue Cross Association website. There you can access the “Find a Doctor or Hospital” option.

- Go to bluecares.com.
- Enter the ID prefix (the first three letters of your member ID number listed on your membership card).
- If you do not know your ID prefix, or are visiting the site, click on “Guest” to start your search. Click on “Continue” after each step.
- Select your product type. (Note: HMO members select “Traditional.”)
- Search by city and state or ZIP code criteria, then type of provider.
- Receive your search results via a listing, map or downloadable directory.

Customer Service

We are committed to providing quality care and service to our members. Our courteous and knowledgeable Customer Service representatives welcome your questions.

Your Customer Service representative:

- Is just a toll-free phone call away
- Can quickly help you find providers in your neighborhood, state or throughout the country
- Offers the most current information on participating providers in our network
- Can verify if your doctor is part of our network

For any questions or concerns about your coverage, simply refer to your ID card for all relevant Customer Service phone numbers. We're at your service!

Enrollment Process







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