



HIPAA Plans

Health Insurance Portability and Accountability Act of 1996

Anthem Blue Cross HIPAA PPO Share 5000 and HIPAA PPO Share 7500

**Anthem Blue Cross Life and Health Insurance Company
HIPAA ClearProtection Plus 1000 and HIPAA ClearProtection Plus 5000**

Rates effective 4/1/12

HIPAA plans

Thank you for choosing Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company for your health care coverage needs.

Eligibility – In order to be eligible for an Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company HIPAA plan, you must:

- Have completed a minimum of 18 months of continuous health coverage, most recently under an employer-sponsored group health plan;
- Have elected and exhausted continuation of coverage under COBRA or Cal-COBRA, if available;
- Have lost coverage within the last 63 days (For reasons other than fraud or non-payment of premiums.)
- Not be eligible for coverage under a group health plan, Medi-Cal, or Medicare, and have no other medical health insurance coverage; and
- Live or work in the service area of the plan applying for.

Eligibility of family members/dependents – must be a permanent legal resident of California and one of the following:

- the applicant's spouse or qualified Domestic Partner who is not Medicare-eligible
- the applicant's children (under 26 years of age), or the children (under 26 years of age) of the enrolling applicant's spouse or qualified Domestic Partner
- the applicant's child (of any age) who is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition and chiefly dependent upon the applicant for support and maintenance

Checklist

Please follow these general guidelines to make sure your application is completed correctly. Applications may take up to 30 days to review from the date Anthem receives them. If complete information is not provided, the application may be returned to you, or we may try to call you to obtain the necessary information.

Please review the checklist before submitting your application.

- The completed application must be received by Anthem within 63 days of losing your prior group or COBRA coverage.
- Print clearly and complete the application in blue or black ink.
- If you make any changes while completing this form, be sure to initial and date those changes.
- The primary applicant, spouse/Domestic Partner, and any applicant 18 years or older if applicable, must sign and date the application.
- Enclose all certificates of creditable coverage from former group health plan(s) or health insurance company(s).
Your coverage will be delayed if proof of creditable coverage is not provided.

The following lists the various situations and the certificates of creditable coverage or alternate documentation we require when submitting a HIPAA application.

The applicant needs to have completed a minimum of 18 months of continuous health coverage, most recently under an employer-sponsored group health plan. Either of the following will meet this requirement:

- Certificate of Creditable Coverage – This must reflect the applicant's last 18 months of continuous coverage and have an end date.
- A letter from the prior employer or insurance carrier reflecting their last 18 months of continuous coverage.

This letter needs to have a start and end date and must state the type of plan you were covered under.

The applicant has elected and exhausted continuation of coverage under COBRA or Cal-COBRA, if available. If COBRA was exhausted, we will need one of the following:

- COBRA Expiration/Termination Letter - This document is usually sent 30-90 days prior to the applicant's COBRA expiration and simply explains that their COBRA will be coming to an end on a specific date.
- A letter from the prior employer or insurance carrier indicating COBRA was exhausted. This letter also needs to list the specific end date.

If Cal-COBRA was offered, we will need:

- A letter from the applicant's prior employer or insurance carrier indicating Cal-COBRA was exhausted. This letter needs to list the specific end date.

If Cal-COBRA was not offered, we will need one of the following:

- A letter from the applicant's prior employer or insurance carrier indicating they are self-insured.
- A letter from the applicant's prior employer or insurance carrier indicating they do not have a contract in the state of California.
- A copy of an Anthem Blue Cross ID card.

Miscellaneous scenarios:

If the applicant's prior group coverage ended and COBRA/Cal-COBRA was not offered, we will need:

- A letter from the employer indicating the reason they are no longer offering group health benefits.

If the applicant's COBRA/Cal-COBRA ended and was not exhausted, we will need:

- A letter from the prior employer indicating the reason why COBRA/Cal-COBRA could not be exhausted.

Payment must be provided within 30 days of Anthem approving your application for coverage. If payment is not received within 30 days, you will not be enrolled under the HIPAA plan applied for and will have no coverage. If your payment is delivered or postmarked, whichever occurs earlier, within the first 15 days of the month, coverage shall begin no later than the first day of the following month. When that payment is neither delivered nor postmarked until after the 15th day of a month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

Overview of coverage — your HIPAA plan choices

... and your share of costs (after deductible, if any)

Your Plan Features	HIPAA PPO Share 5000		HIPAA PPO Share 7500	
	Network	Non-Network	Network	Non-Network
Lifetime Maximum	Unlimited		Unlimited	
Calendar Year Out-of-Pocket Maximum (In addition to deductible)	\$2,500 per member		\$0 per member	
Calendar Year Deductible	\$5,000 per member		\$7,500 per member	
How family deductibles and family out-of-pocket maximums work	Each family member has an individual out-of-pocket maximum. Once 2 members each reach their individual out-of-pocket maximum, the maximum is met for the entire family. Each family member has an individual deductible. Once 2 members each reach their individual deductible, the deductible is met for the entire family.			
Doctor's Office Visits	\$40 copay (deductible waived)	50% coinsurance plus all excess charges (deductible waived)	\$40 copay (deductible waived)	50% coinsurance plus all excess charges (deductible waived)
Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.)	30% coinsurance	50% coinsurance plus all excess charges	0% coinsurance	0% coinsurance
Inpatient Services (overnight hospital/facility stays)	30% coinsurance	All charges except \$650/day	0% coinsurance	All charges except \$650/day
Outpatient Services (without overnight hospital/facility stays)	30% coinsurance	All charges except \$380/day	0% coinsurance	All charges except \$380/day
Emergency Room Services	30% coinsurance plus \$100 Emergency Room copay (copay waived if admitted)	30% coinsurance plus \$100 Emergency Room copay (copay waived if admitted)	0% coinsurance plus \$100 Emergency Room copay (copay waived if admitted)	0% coinsurance plus \$100 Emergency Room copay (copay waived if admitted)
Maternity	30% coinsurance	50% coinsurance	0% coinsurance	0% coinsurance
Preventive Care	Includes all nationally recommended preventive services including well-child care, immunizations, PSA screenings, Pap tests, mammograms and more. 0% coinsurance (not subject to deductible)	50% coinsurance plus all excess charges (deductible waived)	Includes all nationally recommended preventive services including well-child care, immunizations, PSA screenings, Pap tests, mammograms and more. 0% coinsurance (not subject to deductible)	50% coinsurance plus all excess charges (deductible waived)
Prescription Drugs (Anthem Blue Cross Formulary) Amounts shown for each 30-day retail or in-network mail order supply	Generic (Tier 1): \$15 copay Brand-name (Tier 2): \$35 copay after \$750 annual brand name deductible (2 member maximum)	50% of drug limited-fee schedule and all excess charges plus the copay/ coinsurance as stated for in-network benefits; subject to the annual \$750 brand name prescription drug deductible	Generic (Tier 1): \$15 copay or 40%, whichever is greater Brand name (Tier 2): \$15 copay or 40%, whichever is greater after \$750 annual brand name deductible (2 member maximum)	50% of drug limited-fee schedule and all excess charges plus the copay/coinsurance as stated for in-network benefits; subject to the annual \$750 brand name prescription drug deductible

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A more detailed listing of coverage can be found in the Evidence of Coverage/Certificate booklet. For a copy, call Anthem Blue Cross at 800-333-0912.

Notes for HIPAA PPO Share 5000 and PPO Share 7500 plans:

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

This overview provides a brief summary of benefits and services. A more detailed listing of coverage can be found in the Evidence of Coverage/Certificate booklet.

For a copy, contact your agent or call Anthem Blue Cross at 800-333-0912.

Your Plan Features	HIPAA ClearProtection Plus 1000		HIPAA ClearProtection Plus 5000	
	Network	Non-Network	Network	Non-Network
Lifetime Maximum	Unlimited		Unlimited	
Calendar Year Out-of-Pocket Maximum (Includes both Inpatient/Surgical and Outpatient/Professional deductibles or a combination of both)	\$4,500 per individual, \$9,000 per family		\$8,500 per individual, \$17,000 per family	
Calendar Year Deductible Inpatient/Surgical and Emergency Room Services	\$1,000 per individual, \$2,000 per family		\$5,000 per individual, \$10,000 per family	
Calendar Year Deductible Outpatient/Professional and Diagnostic Services	\$4,500 per individual, \$9,000 per family		\$8,500 per individual, \$17,000 per family	
How family deductibles and family out-of-pocket maximums work	Once one family member reaches their deductible or out-of-pocket maximum, the remaining amount of the family deductible or out-of-pocket maximum needs to be met by one or more other family members. The family deductible or out-of-pocket maximum can be met by the family combined.			
Doctor's Office Visits	<i>Network:</i> First 2 office visits per member: \$40 copay, deductible waived. Additional office visits: 100% coinsurance, then 0% coinsurance after satisfying Outpatient/Professional and Diagnostic Services deductible <i>Non-network:</i> 100% coinsurance; then 50% coinsurance after satisfying Outpatient/Professional and Diagnostic Services deductible			
Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.)	<i>Network:</i> Inpatient: 40% coinsurance after satisfying Inpatient/Surgical and Emergency Room Services deductible Outpatient: 100% coinsurance, then 0% coinsurance after satisfying Outpatient/Professional and Diagnostic Services deductible <i>Non-network:</i> Inpatient: 50% coinsurance after satisfying Inpatient/Surgical and Emergency Room Services deductible Outpatient: 100% coinsurance; then 50% coinsurance after satisfying Outpatient/Professional and Diagnostic Services deductible			
Inpatient Services (overnight hospital/facility stays)	<i>Network:</i> 40% coinsurance after satisfying Inpatient/Surgical and Emergency Room Services deductible <i>Non-network:</i> All charges except \$650 per day after satisfying Inpatient/Surgical and Emergency Room Services deductible			
Outpatient Services (without overnight hospital/facility stays)	<i>Network:</i> Surgery: 40% coinsurance after satisfying Inpatient/Surgical and Emergency Room Services deductible <i>Network Other Services:</i> 100% coinsurance; then 0% coinsurance after satisfying Outpatient/Professional and Diagnostic Services deductible <i>Non-network Surgery:</i> All charges except \$380 per day after satisfying Inpatient/Surgical and Emergency Room Services deductible <i>Non-network Other Services:</i> 50% coinsurance after satisfying Outpatient/Professional and Diagnostic Services deductible			
Emergency Room Services	<i>Network and non-network:</i> 40% coinsurance plus \$100 Emergency Room copay (copay waived if admitted overnight) after satisfying Inpatient/Surgical and Emergency Room Services deductible			
Maternity	Not covered			
Preventive Care	Includes all nationally recommended preventive services including well-child care, immunizations, PSA screenings, Pap tests, mammograms and more. <i>Network:</i> 0% coinsurance, not subject to either deductible <i>Non-network:</i> 100% coinsurance; then 50% coinsurance after satisfying Outpatient/Professional and Diagnostic Services deductible			
Prescription Drugs	<i>Network:</i> Generic (Tier 1): \$15 copay \$7,500 annual Prescription Drug deductible per member applies before the following: Formulary brand name (Tier 2): \$40 copay Non-Formulary brand name (Tier 3): \$60 copay Specialty: 25% coinsurance up to a \$2,500 annual Prescription Drug out-of-pocket maximum (the most you'll have to pay) for network only and in addition to \$7,500 annual deductible. <i>Non-network:</i> Not covered			

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

NOTES: Discounted network rates apply for network covered services. For non-network services, member is responsible for the coinsurance plus charges in excess of the allowable amount.

What the medical plans do not cover

Every health plan has exclusions and limitations that describe what the plans do not cover. General exclusions and limitations are listed below for the health plans described in this brochure. Please take a few moments to review these listings. We want you to understand what your coverage does not include before you enroll. These listings are an overview only. Plan-specific Evidence of Coverage and Disclosure Form/Certificate booklets contain a comprehensive list of each plan's exclusions and limitations. For a sample copy of an Evidence of Coverage and Disclosure Form/Certificate booklet, ask your agent or contact us at 800-333-0912.

Exclusions and limitations

- Conditions covered by workers' compensation or similar law
- Experimental or investigative services
- Services provided by a local, state, federal or foreign government, unless you have to pay for them
- Services or supplies not specifically listed as covered under the plan agreement
- Services received before your effective date
- Services received after coverage ends
- Services you wouldn't have to pay for without insurance
- Services from relatives
- Any services received by Medicare benefits without payment of additional premium
- Services or supplies that are not medically necessary
- Routine physical exams, except for preventive care services (e.g., physical exams for insurance, employment, licenses or school are not covered)
- Any amounts in excess of the maximum amounts listed in the Evidence of Coverage and Disclosure Form/Certificate
- Sex changes
- Cosmetic surgery
- Services primarily for weight reduction, except medically necessary treatment of morbid obesity
- Dental care, dental implants or treatment to the teeth, except as specifically stated in the Evidence of Coverage and Disclosure Form/Certificate
- Hearing aids
- Contraceptive drugs and/or certain contraceptive devices, except as specifically stated in the Evidence of Coverage and Disclosure Form/Certificate
- Infertility services
- Private duty nursing
- Eyeglasses or contact lenses, except as specifically stated in the Evidence of Coverage and Disclosure Form/Certificate
- Vision care including certain eye surgeries to replace glasses, except as specifically stated in the Evidence of Coverage and Disclosure Form/Certificate
- Mental and nervous disorders and substance abuse, except as specifically stated in the Evidence of Coverage and Disclosure Form/Certificate
- Certain orthopedic shoes or shoe inserts, except as specifically stated in the Evidence of Coverage and Disclosure Form/Certificate
- Outdoor treatment programs
- Telephone, facsimile machine and electronic consultations
- Educational services, except as specifically provided or arranged by Anthem Blue Cross
- Nutritional counseling
- Food or dietary supplements, except for formulas and special food products to prevent complications of phenylketonuria (PKU)
- Personal comfort items
- Custodial care
- Certain genetic testing
- Outpatient speech therapy, except as specifically stated in the Evidence of Coverage and Disclosure Form/Certificate
- Any amounts in excess of maximums stated in the Combined Evidence of Coverage and Disclosure Form/Certificate
- Services or supplies supplied to any person not covered under the Agreement in connection with a surrogate pregnancy
- Outpatient drugs, medications or other substances dispensed or administered in any outpatient setting

Medical rating area definitions – for HIPAA PPO Share 5000, HIPAA PPO Share 7500, Clear Protection Plus 1000, Clear Protection Plus 5000

Rates for the Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company HIPAA plans are based upon the county in which you reside, your family status and age. For Subscriber & Spouse

and Family, rates are based on the age of the younger spouse. To determine your rate, find your county in the Rating Areas chart below and the rate for your area and category on the rate tables. Rates are recalculated at each billing period based on age and the residence address.

Rating areas

Area 1	Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Mendocino, Modoc, Mono, Monterey, Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo, Yuba
Area 2	Fresno, Imperial, Kern, Madera, Mariposa, Merced, Napa, Sacramento, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Sonoma, Stanislaus
Area 3	Alameda, Contra Costa, Marin, San Francisco, San Mateo, Santa Clara
Area 4	Orange, Santa Barbara, Ventura
Area 5	Los Angeles
Area 6	Riverside, San Bernardino, San Diego

Monthly rates

HIPAA PPO
Share 5000 and
HIPAA PPO
Share 7500

Effective April 1, 2012

	Age Range	Pricing Area					
		Area 1	Area 2	Area 3	Area 4	Area 5	Area 6
Single	<15	\$345	\$307	\$317	\$289	\$304	\$287
	15-29	\$446	\$392	\$405	\$373	\$392	\$370
	30-34	\$594	\$498	\$512	\$475	\$501	\$467
	35-39	\$668	\$551	\$564	\$526	\$556	\$515
	40-44	\$714	\$600	\$616	\$572	\$605	\$563
	45-49	\$764	\$648	\$666	\$617	\$652	\$608
	50-54	\$957	\$787	\$807	\$751	\$795	\$735
	55-59	\$1,139	\$923	\$942	\$882	\$935	\$861
	60-64	\$1,139	\$923	\$942	\$882	\$935	\$861
	65-69	\$1,709	\$1,503	\$1,550	\$1,447	\$1,523	\$1,438
	70-74	\$1,802	\$1,585	\$1,633	\$1,525	\$1,605	\$1,515
75+	\$1,909	\$1,681	\$1,730	\$1,615	\$1,700	\$1,605	
Subscriber & Spouse	<15	\$1,709	\$1,503	\$1,550	\$1,447	\$1,523	\$1,438
	15-29	\$1,802	\$1,585	\$1,633	\$1,525	\$1,605	\$1,515
	30-34	\$1,909	\$1,681	\$1,730	\$1,615	\$1,700	\$1,605
	35-39	\$685	\$611	\$633	\$574	\$601	\$571
	40-44	\$920	\$817	\$843	\$776	\$817	\$771
	45-49	\$1,080	\$947	\$978	\$899	\$947	\$892
	50-54	\$1,180	\$1,039	\$1,071	\$987	\$1,039	\$979
	55-59	\$1,290	\$1,137	\$1,175	\$1,081	\$1,137	\$1,072
	60-64	\$1,507	\$1,272	\$1,305	\$1,211	\$1,279	\$1,192
	65-69	\$3,202	\$2,753	\$2,835	\$2,659	\$2,783	\$2,631
	70-74	\$3,374	\$2,904	\$2,987	\$2,803	\$2,934	\$2,774
75+	\$3,573	\$3,073	\$3,158	\$2,975	\$3,114	\$2,944	
Subscriber & Child	<15	\$1,881	\$1,560	\$1,601	\$1,489	\$1,568	\$1,460
	15-29	\$2,243	\$1,811	\$1,847	\$1,731	\$1,821	\$1,688
	30-34	\$2,243	\$1,811	\$1,847	\$1,731	\$1,821	\$1,688
	35-39	\$3,202	\$2,753	\$2,835	\$2,659	\$2,783	\$2,631
	40-44	\$3,374	\$2,904	\$2,987	\$2,803	\$2,934	\$2,774
	45-49	\$3,573	\$3,073	\$3,158	\$2,975	\$3,114	\$2,944
	50-54	\$685	\$611	\$633	\$574	\$601	\$571
	55-59	\$920	\$817	\$843	\$776	\$817	\$771
	60-64	\$1,080	\$947	\$978	\$899	\$947	\$892
	65-69	\$3,202	\$2,753	\$2,835	\$2,659	\$2,783	\$2,631
	70-74	\$3,374	\$2,904	\$2,987	\$2,803	\$2,934	\$2,774
75+	\$3,573	\$3,073	\$3,158	\$2,975	\$3,114	\$2,944	
Family	<15	\$1,180	\$1,039	\$1,071	\$987	\$1,039	\$979
	15-29	\$1,290	\$1,137	\$1,175	\$1,081	\$1,137	\$1,072
	30-34	\$1,507	\$1,272	\$1,305	\$1,211	\$1,279	\$1,192
	35-39	\$1,881	\$1,560	\$1,601	\$1,489	\$1,568	\$1,460
	40-44	\$2,243	\$1,811	\$1,847	\$1,731	\$1,821	\$1,688
	45-49	\$2,243	\$1,811	\$1,847	\$1,731	\$1,821	\$1,688
	50-54	\$3,202	\$2,753	\$2,835	\$2,659	\$2,783	\$2,631
	55-59	\$3,374	\$2,904	\$2,987	\$2,803	\$2,934	\$2,774
	60-64	\$3,573	\$3,073	\$3,158	\$2,975	\$3,114	\$2,944
	65-69	\$3,928	\$3,458	\$3,566	\$3,289	\$3,452	\$3,264
	70-74	\$4,142	\$3,650	\$3,761	\$3,468	\$3,640	\$3,443
75+	\$4,386	\$3,864	\$3,978	\$3,680	\$3,863	\$3,654	
Subscriber & Children	<15	\$1,100	\$1,012	\$1,052	\$954	\$999	\$950
	15-29	\$1,513	\$1,342	\$1,387	\$1,333	\$1,400	\$1,330
	30-34	\$1,807	\$1,611	\$1,663	\$1,529	\$1,608	\$1,522
	35-39	\$1,921	\$1,670	\$1,719	\$1,588	\$1,671	\$1,572
	40-44	\$1,968	\$1,705	\$1,758	\$1,622	\$1,710	\$1,605
	45-49	\$2,145	\$1,797	\$1,843	\$1,714	\$1,809	\$1,683
	50-54	\$2,457	\$2,030	\$2,080	\$1,938	\$2,042	\$1,898
	55-59	\$2,750	\$2,182	\$2,221	\$2,089	\$2,199	\$2,029
	60-64	\$2,750	\$2,182	\$2,221	\$2,089	\$2,199	\$2,029
	65-69	\$3,928	\$3,458	\$3,566	\$3,289	\$3,452	\$3,264
	70-74	\$4,142	\$3,650	\$3,761	\$3,468	\$3,640	\$3,443
75+	\$4,386	\$3,864	\$3,978	\$3,680	\$3,863	\$3,654	

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The HIPAA PPO Share 5000 and HIPAA PPO Share 7500 plans are offered by Anthem Blue Cross Life and Health Insurance Company.

Notes:

For Subscriber & Spouse and Family, rates are based on the age of the younger spouse.

For more information, call your agent or Anthem Blue Cross at 800-333-0912.

Monthly rates

ClearProtection
Plus 1000 and
ClearProtection
Plus 5000

Effective April 1, 2012

		Pricing Area					
Age Range		Area 1	Area 2	Area 3	Area 4	Area 5	Area 6
Single	<15	\$345	\$306	\$316	\$288	\$303	\$286
	15-29	\$446	\$391	\$404	\$372	\$391	\$368
	30-34	\$593	\$497	\$510	\$474	\$500	\$464
	35-39	\$668	\$549	\$562	\$525	\$554	\$512
	40-44	\$714	\$598	\$614	\$571	\$603	\$560
	45-49	\$764	\$646	\$664	\$616	\$650	\$605
	50-54	\$956	\$785	\$804	\$750	\$792	\$731
	55-59	\$1,138	\$920	\$939	\$880	\$931	\$856
	60-64	\$1,138	\$920	\$939	\$880	\$931	\$856
	65-69	\$1,708	\$1,500	\$1,546	\$1,445	\$1,520	\$1,434
	70-74	\$1,801	\$1,583	\$1,629	\$1,523	\$1,601	\$1,511
75+	\$1,908	\$1,678	\$1,726	\$1,614	\$1,697	\$1,600	
Subscriber & Spouse	<15	\$1,708	\$1,500	\$1,546	\$1,445	\$1,520	\$1,434
	15-29	\$1,801	\$1,583	\$1,629	\$1,523	\$1,601	\$1,511
	30-34	\$1,908	\$1,678	\$1,726	\$1,614	\$1,697	\$1,600
	35-39	\$684	\$610	\$632	\$573	\$601	\$569
	40-44	\$920	\$816	\$841	\$775	\$815	\$769
	45-49	\$1,080	\$946	\$975	\$898	\$945	\$889
	50-54	\$1,179	\$1,037	\$1,068	\$986	\$1,037	\$976
	55-59	\$1,289	\$1,135	\$1,172	\$1,079	\$1,135	\$1,069
	60-64	\$1,505	\$1,269	\$1,301	\$1,209	\$1,275	\$1,187
	65-69	\$3,199	\$2,748	\$2,827	\$2,655	\$2,783	\$2,621
	70-74	\$3,372	\$2,898	\$2,979	\$2,799	\$2,934	\$2,764
75+	\$3,571	\$3,067	\$3,149	\$2,971	\$3,113	\$2,934	
Subscriber & Child	<15	\$1,879	\$1,556	\$1,595	\$1,486	\$1,568	\$1,452
	15-29	\$2,241	\$1,805	\$1,840	\$1,727	\$1,820	\$1,678
	30-34	\$2,241	\$1,805	\$1,840	\$1,727	\$1,820	\$1,678
	35-39	\$3,199	\$2,748	\$2,827	\$2,655	\$2,783	\$2,621
	40-44	\$3,372	\$2,898	\$2,979	\$2,799	\$2,934	\$2,764
	45-49	\$3,571	\$3,067	\$3,149	\$2,971	\$3,113	\$2,934
	50-54	\$684	\$610	\$632	\$573	\$601	\$569
	55-59	\$920	\$816	\$841	\$775	\$815	\$769
	60-64	\$1,080	\$946	\$975	\$898	\$945	\$889
	65-69	\$3,199	\$2,748	\$2,827	\$2,655	\$2,783	\$2,621
	70-74	\$3,372	\$2,898	\$2,979	\$2,799	\$2,934	\$2,764
75+	\$3,571	\$3,067	\$3,149	\$2,971	\$3,113	\$2,934	
Family	<15	\$1,179	\$1,037	\$1,068	\$986	\$1,037	\$976
	15-29	\$1,289	\$1,135	\$1,172	\$1,079	\$1,135	\$1,069
	30-34	\$1,505	\$1,269	\$1,301	\$1,209	\$1,275	\$1,187
	35-39	\$1,879	\$1,556	\$1,595	\$1,486	\$1,568	\$1,452
	40-44	\$2,241	\$1,805	\$1,840	\$1,727	\$1,820	\$1,678
	45-49	\$2,241	\$1,805	\$1,840	\$1,727	\$1,820	\$1,678
	50-54	\$3,199	\$2,748	\$2,827	\$2,655	\$2,783	\$2,621
	55-59	\$3,372	\$2,898	\$2,979	\$2,799	\$2,934	\$2,764
	60-64	\$3,571	\$3,067	\$3,149	\$2,971	\$3,113	\$2,934
	65-69	\$3,925	\$3,453	\$3,558	\$3,286	\$3,451	\$3,254
	70-74	\$4,139	\$3,645	\$3,753	\$3,464	\$3,640	\$3,432
75+	\$4,383	\$3,858	\$3,969	\$3,676	\$3,861	\$3,643	
Subscriber & Children	<15	\$1,100	\$1,009	\$1,051	\$953	\$999	\$949
	15-29	\$1,513	\$1,341	\$1,384	\$1,332	\$1,398	\$1,328
	30-34	\$1,806	\$1,609	\$1,660	\$1,528	\$1,605	\$1,517
	35-39	\$1,920	\$1,668	\$1,714	\$1,586	\$1,670	\$1,566
	40-44	\$1,967	\$1,702	\$1,753	\$1,620	\$1,706	\$1,599
	45-49	\$2,143	\$1,792	\$1,837	\$1,710	\$1,805	\$1,675
	50-54	\$2,455	\$2,025	\$2,073	\$1,934	\$2,041	\$1,888
	55-59	\$2,747	\$2,174	\$2,212	\$2,083	\$2,197	\$2,015
	60-64	\$2,747	\$2,174	\$2,212	\$2,083	\$2,197	\$2,015
	65-69	\$3,925	\$3,453	\$3,558	\$3,286	\$3,451	\$3,254
	70-74	\$4,139	\$3,645	\$3,753	\$3,464	\$3,640	\$3,432
75+	\$4,383	\$3,858	\$3,969	\$3,676	\$3,861	\$3,643	

CNKFGRRNQZ

Notes:

For Subscriber & Spouse and Family, rates are based on the age of the younger spouse. For more information, call your agent or Anthem Blue Cross at 800-333-0912.

No-obligation review period

After you enroll in an Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company health plan, you will receive an Evidence of Coverage/Certificate booklet that explains the exact terms and conditions of coverage, including the plan's exclusions and limitations. You have 30 full days to examine your plan's features. During that time, if you are not fully satisfied, you may decline by returning your Evidence of Coverage/Certificate booklet along with a letter notifying us that you wish to discontinue coverage. Evidence of Coverage/Certificate booklets are available for you to examine prior to enrolling by contacting your agent or calling Anthem Blue Cross at 800-333-0912. Once you enroll in an Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company HIPAA plan, you will have 30 days from the date of enrollment to change to a different HIPAA plan. Your effective date will be the same as the date of your original enrollment. No further changes will be allowed after you have been enrolled for 30 days.

Incurred medical care ratio

As required by law, we are advising you that Anthem Blue Cross' medical loss ratio for 2010 was 85.4 percent. The 2010 medical loss ratio for Anthem Blue Cross Life and Health Insurance Company was 79.1 percent. These ratios were calculated after provider discounts were applied and based on regulatory rules and regulations.

Utilization management and case management

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

Prospective review/Pre-admission review

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

- inpatient hospitalizations
- outpatient procedures
- diagnostic procedures
- therapy services
- durable medical equipment

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

Concurrent review

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

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

Retrospective review

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

Case management

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

Application for Coverage under HIPAA

(Health Insurance Portability and Accountability Act)



1. Applicant Information

Please print in blue or black ink

Applicant's Last Name	First Name	M.I.
Home Address (Must be complete: PO Box not acceptable)*		
City	State	ZIP Code

*All information will be mailed to your Home Address, including billing, private and confidential communications as defined by California law, unless you designate a different address under the "Mailing Address" field below. This will not impact rights you may have to invoke a separate Confidential Communication under the Health Insurance and Portability and Accountability Act ("HIPAA").

2. Choice of Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Individual Coverage

Choose one plan per application

- HIPAA ClearProtection Plus 1000 (OJT9) HIPAA PPO Share 5000 (OJT7)**
 HIPAA ClearProtection Plus 5000 (OJTA) HIPAA PPO Share 7500 (OJT8)**

Mailing Address (if different than above) or PO Box, Private Mail Box (PMB) No.		Daytime Phone No. () ()	Fax Phone No. () ()
City / State / ZIP Code	County (Required)	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Domestic Partnership <input type="checkbox"/> Married	Applicant/Spouse Maiden Name
Email Address	If possible, do you want email notification? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has any person listed on this application resided outside the U.S. for the past three (3) consecutive months? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Language Choice (Optional)	<input type="checkbox"/> English (ENG) <input type="checkbox"/> Korean (KOR) <input type="checkbox"/> Vietnamese (VIE) <input type="checkbox"/> Tagalog (TGL)	<input type="checkbox"/> Spanish (SPA) <input type="checkbox"/> Chinese (ZHO) (C/M) <input type="checkbox"/> Other (W09) _____	

Applicant DOES speak, read and/or write English. If applicant does not speak, read or write English, the interpreter must sign and submit a Statement of Accountability (see Section 7).

**These products are administered by Anthem Blue Cross and are regulated by the California Department of Managed Health Care. All other products are administered by Anthem Blue Cross Life and Health and are regulated by the California Department of Insurance.

3. Family Members and Dependents Applying

Please list ALL eligible family members and dependents applying.

If a listed family member or dependent's last name is different from your own, please explain on a separate sheet of paper.

Relation	Last Name	First Name	M	Social Security or ID No.	Date of Birth	Age
10 <input type="checkbox"/> Male 20 <input type="checkbox"/> Female	Yourself					
30 <input type="checkbox"/> Male 40 <input type="checkbox"/> Female	Spouse***					
<input type="checkbox"/> Son <input type="checkbox"/> Daughter						
<input type="checkbox"/> Son <input type="checkbox"/> Daughter						
<input type="checkbox"/> Son <input type="checkbox"/> Daughter						
<input type="checkbox"/> Son <input type="checkbox"/> Daughter						

***Spouse includes domestic partner (when applicable). Dependent information must be completed for all additional child dependents (if any) to be covered under this

coverage. An eligible dependent may be your children, or your spouse or domestic partner's children (to the end of the calendar month in which they turn 26-30).

(List all dependents beginning with the eldest.)



4. Eligibility

1. Have all applicants had a minimum of 18 months of continuous health coverage most recently under an employer-sponsored group health plan that ended within the last 63 days for a reason other than fraud or non-payment of premium? Yes No
If yes, please attach the Certificate of Creditable Coverage provided by your former employer or carrier OR letter from the employer giving us the start and end date of coverage.
Name of insurance carrier: _____ Phone No. (____) _____
If no for any applicant, then he or she is **not eligible** for this guarantee issue plan.
2. Did all applicants elect and exhaust any continuation coverage available under COBRA or Cal-COBRA? Yes No
If yes, date coverage started (Mo/Day/Yr) _____ Date coverage ended (Mo/Day/Yr) _____
If no, please explain:
If all available COBRA or Cal-COBRA is not exhausted for any applicant, then he or she is **not eligible** for this coverage.
3. Is any applicant currently covered by or eligible for Medicaid, Medicare or any health coverage? Yes No
If yes for any applicant, then he or she is **not eligible** for this coverage.
4. Has any applicant lost coverage for fraud or failure to pay premiums? Yes No
If yes, then he or she is **not eligible** for this coverage.

5. Prior Insurance History

For any period of creditable coverage for which you are unable to provide a certificate of creditable coverage, please complete the following section for the last two years, beginning with the most recent coverage. Please include any COBRA and Cal-COBRA continuation coverage. Attach additional sheet if necessary.

Applicant name(s) OR <input type="checkbox"/> All applicants	Insurer Name (and Phone Number)	Policyholder ID Number	
Plan/Policy Name	State	Effective Date of Coverage	Coverage End Date

Type of Coverage: Group Individual Other

6. Application Understandings, Conditions and Agreement

IMPORTANT: You, the applicant, are solely responsible to review and attest to the completeness and validity of information provided on this application. It is important that you carefully read and fully understand the following:

All Applicants

I, the undersigned, understand that under the Anthem Blue Cross plan and/or Anthem Blue Cross Life and Health Insurance Company policy for which I am applying, I will have considerably higher personal financial costs if I use an out-of-network hospital or physician than if I use a network hospital or physician. Contact customer service at 1-800-333-0912 with any questions about the use of network providers and the financial impact of using out-of-network providers.

HIV Testing PROHIBITED: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.

Agreement

By requesting coverage, I, the undersigned, agree to the following:

1. Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company may decline my application. No coverage comes into effect until Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company approves this application and informs me in writing. The effective date of my coverage, if this application is accepted, will be assigned by Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company **based on when payment is received. Anthem will send you billing information within 30 days of approving your application. Payment must be provided within 30 days. If payment is not received within 30 days, you will not be enrolled under the HIPAA plan applied for and will have no coverage. If your payment is delivered or postmarked, whichever occurs earlier, within the first 15 days of the month, coverage shall begin no later than the first day of the following month. When that payment is neither delivered nor postmarked until after the 15th day of a month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.**
2. The selling agent has no authority to promise me coverage or to modify Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company underwriting policy or the terms of any Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company coverage.
3. If the applicant is a minor, I accept full legal and financial responsibility for the coverage and information provided on this application. (Court documents establishing guardianship must be submitted if the responsible adult is not the parent.)
4. In no event shall Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company or any affiliated company have any liability to the applicant if the application is not approved, and neither shall any coverage exist nor shall the applicant be entitled to any benefits unless and until this application is approved by the Medical Underwriting Department of Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company.
5. I understand and agree that I am applying for an individual health coverage policy which is not part of any employer-sponsored plan and the policy, if issued, shall not be used as an employer-sponsored health benefit plan. If the policy is issued, I understand and agree that I am responsible for 100% of the premium and I must ensure that premiums are paid timely. I certify that no employer of any person covered under this policy will pay any premium for this health coverage policy, directly or indirectly, through wage adjustments or otherwise. If my employer has agreed to remit my premium payment to Anthem Blue Cross **and/or** Anthem Blue Cross Life and Health on my behalf, my employer will not directly or indirectly contribute to that payment and will only forward to Anthem Blue Cross **and/or** Anthem Blue Cross Life and Health my premium payment that is directly funded by the regular wages paid to me by my employer.
6. By checking this box, I expressly consent to receive calls made by or on behalf of Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company and its affiliated companies, contractors and vendors that use an automated dialing system or deliver prerecorded messages, including telemarketing sales calls that encourage the purchase of goods or services, to any of the telephone numbers I have provided in this Application. All calls made pursuant to this provision shall be limited to information regarding benefits, services or discounts available under health benefit plans offered or administered by Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company and its affiliated companies. I also understand that my consent to receive such calls is voluntary and may be discontinued by calling Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company. The benefits available under health benefit plans offered or administered by Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company and its affiliates will not be altered in any way if I do not consent to calls made under this provision.
7. I understand that my domestic partner, if applicable, is eligible for coverage only if he or she has established a domestic partnership with me pursuant to California law.
8. When answering questions on this enrollment application the information provided for each individual should include only information about that individual, and should not include any genetic information. Genetic information includes family medical history and information related to the individual's genetic testing, genetic services, genetic counseling, or genetic diseases for which the individual may be at risk. All responses pertaining to an individual will be considered and applied only to the individual in question.



6. Application Understandings, Conditions and Agreement - continued

I have personally read and attest to the completeness and validity of the information provided on this application. If I am accepted, this application will become part of the plan contract/policy between Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company and me.

I, and any enrolled family members, agree to abide by the terms of that plan contract/policy. With the exception of minors and persons for whom this application has been interpreted (a signed Statement of Accountability must be attached, see Section 7) all persons applying for coverage agree that they have personally answered all questions directed to them. If an Applicant does not read English, the interpreter must sign and submit a Statement of Accountability for interpreting this entire application (see Section 7).

REQUIREMENTS FOR BINDING ARBITRATION

The following provision does not apply to class actions:

IF YOU ARE APPLYING FOR COVERAGE, PLEASE NOTE THAT ANTHEM BLUE CROSS AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY REQUIRE BINDING ARBITRATION TO SETTLE ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT. *It is understood that any disputes including disputes relating to the delivery of services under the plan/policy or any other issues related to the plan/policy, including any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. THIS MEANS THAT YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY ARE WAIVING THE RIGHT TO A JURY TRIAL FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY.*

Signatures (Required) – IMPORTANT: All applicants age 18 and over must personally read, agree to, sign and date this application.

Applicant/Parent or Legal Guardian	Today's Date	Applicant's Spouse/Domestic Partner	Today's Date
X		X	
Applicant's Dependent age 18 or over	Today's Date	Applicant's Dependent age 18 or over	Today's Date
X		X	

■ **IMPORTANT: All signatures MUST include today's date** ■



7. Statement of Accountability – Complete when the applicant cannot fill out the application for coverage under HIPAA.

I, _____, personally read and completed this application for the applicant named below because:

- Applicant does not read English
 Applicant does not speak English
 Applicant does not write English
 Applicant is Limited English Proficient
 Other (explain): _____

I interpreted the contents of this form and to the best of my knowledge obtained and listed all the requested information disclosed by the: Applicant or by: _____

I also interpreted and fully explained the “Application Understandings and the Conditions and Agreement.”

Signature of Interpreter (Required) X	Today's Date (Required)
I confirm that the application was interpreted on my behalf. Signature of Applicant (Required) X	Today's Date (Required)

Language interpreted (e.g. Spanish): _____

8. To be completed by the Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company Appointed Agent

- Are you aware of any information not disclosed on this application relating to the health of any person listed on this application that may have a bearing on underwriting? Yes No
- Did you see the proposed subscriber (and spouse/domestic partner, if applying) at the time this application was executed? Yes No
If no, please explain: _____
- I certify that, to the best of my knowledge and belief, the responses herein are accurate.
- Please check one of the following and complete the information below:
 - I have not had any interactions whatsoever with this applicant either by phone, e-mail or in person and did not provide any information, advise or assist the applicant in any manner in providing answers or responses to any questions in the application.
 - I assisted the applicant in submitting this application. To the best of my knowledge, the information on this application is complete and accurate. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information and the applicant understood the explanation.

NOTICE: If you state any material fact that you know to be false, you are subject to a civil penalty of up to ten thousand dollars (\$10,000), as authorized under California Health and Safety Code Section 1389.8(c)/Insurance Code Section 10119.3.

Signature of Agent (Required)		Date (Required)
Name of Agent (Print name) John Conner		Agent's Street Address 10425 Saddle Creek Drive Suite No.
Agent I.D. No. C N K F G R R N Q Z		City / State / ZIP Code Sacramento, CA. 95829
Phone No. (916) 682-1117	Fax No. (916) 258-0296	Email Address john@johnconner.com

Please mail to:

Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company
 PO Box 9041
 Oxnard, CA 93031-9041
 OR
 Fax to: 1-800-327-9255

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