California Individual Conversion Plans

For Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company group members converting to an Individual plan.

Anthem Blue Cross Conversion PPO Share 7500 - Rates effective 4/1/12

Anthem Blue Cross Life and Health Insurance Company Conversion ClearProtection Plus 5000 - Rates effective 4/1/12

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CALIFORNIA INDIVIDUAL CONVERSION PLANS

Are you eligible for a California Conversion Plan?

To qualify for these California Conversion plans/policies, all of the following requirements must be met:

- you lost your Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company group coverage within the last 63 days
- you were continuously covered during the 3-month period immediately preceding the termination of your Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company group coverage
- you are not eligible for and do not have Medicare
- you are eligible or covered for hospital, medical, or surgical benefits under any arrangement of coverage for persons in a group, whether insured or self-insured
- you are covered for similar benefits under any individual policy or contract
- your employer's group coverage was not replaced within 15 days of the termination of coverage

If you enroll in a California Conversion Plan/Policy, your eligible dependents who were covered under your employer's plan may also enroll, including:

- your spouse or qualified domestic partner
- your unmarried children under age 26
- your children (under 26 years of age) or the children (under 26 years of age) of your enrolling spouse or qualified domestic partner
- your child (of any age) who is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition and is chiefly dependent upon you for support and maintenance

Applying for California Conversion Plan Coverage

To enroll for these California Conversion plans/policies, you must submit: an application, your first premium payment, and a Certificate of Creditable Coverage (indicating the last date you were covered under your employer-sponsored plan) or other documentation of prior coverage and the loss of that coverage. These must be received by Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company within 63 days following the termination of your employer-sponsored coverage or you become ineligible for this plan.

Upon approval, coverage under your California Conversion Plan/Policy will become effective retroactively to the date your employer-sponsored group coverage was terminated.

What California Conversion Plan is available to you?

- **Conversion PPO Share 7500**

  This plan/policy is offered by Anthem Blue Cross and is only available to eligible members leaving an Anthem Blue Cross group plan.

- **Conversion ClearProtection Plus 5000**

  This plan/policy is offered by Anthem Blue Cross Life and Health Insurance Company and is only available to eligible members leaving an Anthem Blue Cross Life and Health Insurance Company group plan.

Note: Ask your employer or Anthem agent if the group plan you are leaving is offered by Anthem Blue Cross or by Anthem Blue Cross Life and Health Insurance Company. This will determine which Conversion plan is available to you.

Do you have other coverage options?

- You can apply for coverage under a medically underwritten Individual plan. These plans may be less expensive. To apply, you must fill out a health statement that will be reviewed by Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company. Once the underwriting review is completed, you will be notified that your application is either approved or denied. If approved, you will be informed of the date that your coverage will begin. Some pre-existing conditions may not be covered. For more information, please contact your authorized Anthem Blue Cross agent or call 800-777-6000.
- If you are 65 or older and covered under both Parts A and B of Medicare, you can apply for one of our Medicare Supplement plans. If you apply as soon as you leave your group, your coverage begins immediately. For more information about a Medicare Supplement plan, please contact your authorized Anthem Blue Cross agent or call 800-765-2585.
- You may have an option to continue your group coverage through COBRA or Cal-COBRA. Contact your employer for more information.

For more information about Conversion plans, please call 800-333-0912

CALIFORNIA CONVERSION PLANS

and your share of costs (after deductibles)

Your Plan Features	Conversion ClearProtection Plus 5000	
	Network	Non-Network
Lifetime Maximum	Unlimited	
Calendar Year Out-of-Pocket Maximum[1] (The most you will have to pay)	Individual: $8500 Family: $17,000	
Calendar Year Deductible	For Inpatient/Surgical and Emergency Room Services Individual: $5000 Family: $10,000	For Outpatient/Professional and Diagnostic Services Individual: $8500 Family: $17,000
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	
Doctors' Office Visits	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	100% coinsurance; then 50% coinsurance after satisfying Outpatient/Professional and Diagnostic Services deductible
Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.)	**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	**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)	40% coinsurance after satisfying Inpatient/Surgical and Emergency Room Services deductible	All charges except $650 per day after satisfying Inpatient/Surgical and Emergency Room Services deductible
Outpatient Services (without overnight hospital/facility stays)	**Surgery**: 40% coinsurance after satisfying Inpatient/Surgical and Emergency Room Services deductible **Other Services**: 100% coinsurance; then 0% coinsurance after satisfying Outpatient/Professional and Diagnostic Services deductible	**Surgery**: All charges except $380 per day after satisfying Inpatient/Surgerical and Emergency Room **Other Services**: 50% coinsurance after satisfying Outpatient/Professional and Diagnostic Services deductible
Emergency Room Services	40% coinsurance plus $100 Emergency Room copay (copay waived if admitted overnight)after satisfying Inpatient/ Surgerical 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.	
	0% coinsurance, not subject to either deductible	100% coinsurance; then 50% coinsurance coinsurance after satisfying Outpatient/Professional and Diagnostic Services deductible.
Prescription Drugs **(Anthem Blue Cross Formulary) Amounts shown are for each 30-day retail or in-network mail order supply**	**Tier 1** (Generic drugs): $15 copay $7,500 annual prescription drug deductible per member applies before the following: **Tier 2** (Formulary Brand name drugs): $40 copay **Tier 3** (Non-Formulary Brand name drugs): $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.	not covered

1 Excludes non-participating charges in excess of Anthem Blue Cross negotiated fee and non-participating charges in excess of customary and reasonable fees for emergency care. Copays/coinsurance to participating and non-participating providers apply to out-of-pocket maximum except where specifically noted in the policy.

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. Copays/Coinsurance to network and non-network providers apply to annual out-of-pocket maximum except where specifically noted in the Policy.

Your Plan Features	Conversion PPO Share 7500	
	Network	Non-Network
Lifetime Maximum	Unlimited	
Calendar Year Out-of-Pocket Maximum[1] (The most you will have to pay - includes deductible)	$7,500 per member	
Calendar Year Deductible	$7,500 per member	
How family deductibles and family out-of-pocket maximums work	Each family member has an individual deductible. Once 2 members each reach their individual deductible, the deductible is satisfied for the entire family. Each family member has an individual out-of-pocket maximum. Once 2 members each reach their individual out-of-pocket maximum, the maximum is satisfied for the entire family.	
Doctors' Office Visits	$40 copay (deductible waived)	50% coinsurance (deductible waived)
Professional and Diagnostic Services (X-ray, lab, anesthesia, surgeon, etc.)	0% coinsurance	0% coinsurance
Inpatient Services (overnight hospital/facility stays)	0% coinsurance	All charges except $650 per day
Outpatient Services (without overnight hospital/facility stays)	0% coinsurance	All charges except $380 per day
Emergency Room Services	0% coinsurance plus $100 Emergency Room copay (copay waived if admitted)	0% coinsurance plus $100 Emergency Room copay (copay waived if admitted)
Maternity	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 (deductible waived)
Prescription Drugs **(Anthem Blue Cross Formulary) Amounts shown are for each 30-day retail or in-network mail order supply**	**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 $750 annual brand-name prescription drug deductible

A more detailed listing of coverage can be found in the Policy/EOC booklet. For a copy, call your agent or Anthem at 800-333-0912.

1 Excludes non-participating charges in excess of Anthem Blue Cross negotiated fee and non-participating charges in excess of customary and reasonable fees for emergency care. Copays/coinsurance to participating and non-participating providers apply to out-of-pocket maximum except where specifically noted in the policy.

Notes:

- 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.

WHAT THESE CONVERSION PLANS/POLICIES DO NOT COVER

A more detailed listing can be found in the Policy/Evidence of Coverage (EOC) booklet.

- Conditions covered by workers' compensation or similar laws
- 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 Policy/Plan
- 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 Policy/Plan
- Hearing aids
- Contraceptive drugs and/or certain contraceptive devices, except as specifically stated in the Policy/Plan
- Infertility services
- Private duty nursing
- Eyeglasses or contact lenses, except as specifically stated in the Policy/Plan
- Vision care including certain eye surgeries to replace glasses, except as specifically stated in the Policy/Plan
- Mental and nervous disorders and substance abuse, except as specifically stated in the Policy/Plan
- Certain orthopedic shoes or shoe inserts, except as specifically stated in the Policy/Plan
- Personal comfort items
- Custodial care
- Certain genetic testing
- Outpatient speech therapy, except as specifically stated in the Policy/Plan
- Any amounts in excess of maximums stated in the Combined Policy/Plan
- 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

RIGHTS AND OBLIGATIONS

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 a Policy/EOC booklet that explains the exact terms and conditions of coverage, including the plan's exclusions and limitations. You have full days to examine your plan's features. During that time, if you are not fully satisfied, you may decline by returning your Policy/EOC booklet along with a letter notifying us that you wish to discontinue coverage. Policy/EOC booklets are available for you to examine prior to enrolling. Ask your Anthem Blue Cross agent.

Medical Care Ratio

As required by law, we are advising you that Anthem Blue Cross' medical loss ration 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.

How to Enroll

If you are interested in enrolling in one of these California Individual Conversion plans/policies, complete the Enrollment Form for California Individual Conversion Plans and return it with your Certificate of Creditable Coverage from your previous group plan and your payment to:

Anthem Blue Cross/Anthem Blue Cross Life
and Health Insurance Company
P.O. Box 9051
Oxnard, CA 93031-9051

End of Coverage

Your coverage under the California Individual Conversion Plan/Policy stops when any of the following occurs:

- Premiums are not paid
- For a covered spouse, when the marriage ends
- You become ineligible or cancel your coverage
- You are absent from California for more than six (6) consecutive months
- For a domestic partner, when the domestic partner no longer satisfies all eligibility requirements and the domestic partnership has terminated

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.

MEDICAL RATING AREA DEFINITIONS — FOR CONVERSION RE 7500 AND CLEARPROTECTION PLUS 5000

Rates for the Anthem Conversion PPO Share 5000 plan and ClearProtection Plus 5000 policy 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

Payment Methods

You may choose one of the following payment methods:

- Monthly billing — only available with Monthly Checking Account Premium Payment Authorization
- Bimonthly (two-month) billing
- Quarterly (three-month) billing

See the application for instructions regarding your first premium payment.

MONTHLY RATES — CONVERSION PPO SHARE 7500

Rates to be assigned by Anthem

The rates contained in the following rate sheet is subject to change. An applicant's rate shall be set by Anthem pursuant to the rates effective at the time of approval of the application and shall control over any rate referenced in the following rate sheet.

		Conversion PPO Share 7500					
	Age	Pricing Area					
	Range	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	$685	$611	$633	$574	$601	$571
	15-29	$920	$817	$843	$776	$817	$771
	30-34	$1,080	$947	$978	$899	$947	$892
	35-39	$1,180	$1,039	$1,071	$987	$1,039	$979
	40-44	$1,290	$1,137	$1,175	$1,081	$1,137	$1,072
	45-49	$1,507	$1,272	$1,305	$1,211	$1,279	$1,192
	50-54	$1,881	$1,560	$1,601	$1,489	$1,568	$1,460
	55-59	$2,243	$1,811	$1,847	$1,731	$1,821	$1,688
	60-64	$2,243	$1,811	$1,847	$1,731	$1,821	$1,688
	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	$685	$611	$633	$574	$601	$571
	15-29	$920	$817	$843	$776	$817	$771
	30-34	$1,080	$947	$978	$899	$947	$892
	35-39	$1,180	$1,039	$1,071	$987	$1,039	$979
	40-44	$1,290	$1,137	$1,175	$1,081	$1,137	$1,072
	45-49	$1,507	$1,272	$1,305	$1,211	$1,279	$1,192
	50-54	$1,881	$1,560	$1,601	$1,489	$1,568	$1,460
	55-59	$2,243	$1,811	$1,847	$1,731	$1,821	$1,688
	60-64	$2,243	$1,811	$1,847	$1,731	$1,821	$1,688
	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

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 — CONVERSION PPO SHARE 7500

Rates to be assigned by Anthem

The rates contained in the following rate sheet is subject to change. An applicant's rate shall be set by Anthem pursuant to the rates effective at the time of approval of the application and shall control over any rate referenced in the following rate sheet.

		Conversion PPO Share 7500					
	Age	Pricing Area					
	Range	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6
Family	<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
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

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 — CONVERSION CLEAR PROTECTION PLUS 5000

Rates to be assigned by Anthem

The rates contained in the following rate sheet is subject to change. An applicant's rate shall be set by Anthem pursuant to the rates effective at the time of approval of the application and shall control over any rate referenced in the following rate sheet.

		ClearProtection Plus 5000					
	Age Range	Pricing Area					
		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	$684	$610	$632	$573	$601	$569
	15-29	$920	$816	$841	$775	$815	$769
	30-34	$1,080	$946	$975	$898	$945	$889
	35-39	$1,179	$1,037	$1,068	$986	$1,037	$976
	40-44	$1,289	$1,135	$1,172	$1,079	$1,135	$1,069
	45-49	$1,505	$1,269	$1,301	$1,209	$1,275	$1,187
	50-54	$1,879	$1,556	$1,595	$1,486	$1,568	$1,452
	55-59	$2,241	$1,805	$1,840	$1,727	$1,820	$1,678
	60-64	$2,241	$1,805	$1,840	$1,727	$1,820	$1,678
	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	$684	$610	$632	$573	$601	$569
	15-29	$920	$816	$841	$775	$815	$769
	30-34	$1,080	$946	$975	$898	$945	$889
	35-39	$1,179	$1,037	$1,068	$986	$1,037	$976
	40-44	$1,289	$1,135	$1,172	$1,079	$1,135	$1,069
	45-49	$1,505	$1,269	$1,301	$1,209	$1,275	$1,187
	50-54	$1,879	$1,556	$1,595	$1,486	$1,568	$1,452
	55-59	$2,241	$1,805	$1,840	$1,727	$1,820	$1,678
	60-64	$2,241	$1,805	$1,840	$1,727	$1,820	$1,678
	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

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 — CONVERSION CLEAR PROTECTION PLUS 5000

Rates to be assigned by Anthem

The rates contained in the following rate sheet is subject to change. An applicant's rate shall be set by Anthem pursuant to the rates effective at the time of approval of the application and shall control over any rate referenced in the following rate sheet.

		ClearProtection Plus 5000					
	Age Range	Pricing Area					
		Area 1	Area 2	Area 3	Area 4	Area 5	Area 6
Family	<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
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

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.

Payment Methods for Individual Coverage
California

Anthem BlueCross

Applicant/Member Name	Primary Applicant's Social Security No.

Premium Payment is required. Please choose from Option 1 or 2.

☐ **OPTION 1 –** If you choose the following option for **INITIAL and FUTURE MONTHLY** payments, you are **NOT** required to make a selection from Option 2 for your initial payment.

☐ Monthly Checking Account Automatic Premium Payment (complete Section A)

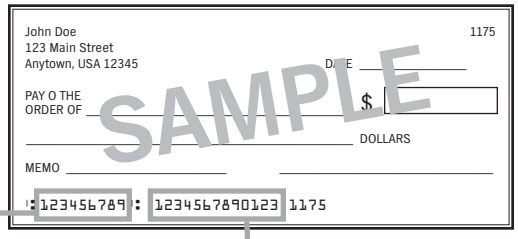
☐ **OPTION 2 –** If you did not select **OPTION 1**, please choose from the options below for your **INITIAL** premium payment. If you choose one of these options, you will receive a bill every month thereafter.

☐ Paper Check* ☐ Electronic Check (complete Section B) ☐ Credit/Debit Card (complete Section C)

DO NOT SUBMIT PREMIUM FOR ANY LIFE INSURANCE – IF ACCEPTED, YOU WILL BE BILLED.

A. Monthly Checking Account Automatic Premium Payment – By providing your check information, you authorize us to electronically debit your bank account. If you have selected this option, **your bank account will be debited one month's premium as soon as the day of approval**. This will include all products selected, including dental and/or life. Subsequent premium amounts will be debited on the day you request below:

Requested Debit Day: _____ (1st to 6th of each month). If no date is requested, your premiums will be debited on the first of each month.



Provide your Routing and Account Numbers here:

9-digit Bank Routing Number	Bank Account Number

As a convenience to me, I request and authorize you to pay and charge to my account checks drawn on that account by and payable to the order of Anthem Blue Cross, provided there are sufficient collected funds in said account to pay the same upon presentation. I understand that the initial payment amount may vary as a result of change(s) during underwriting, and/or subsequent payment amount may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents or moving my residence. I agree that your rights in respect to each such debit shall be the same as if it were a check signed personally by me. I authorize Anthem Blue Cross to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Anthem Blue Cross premiums. This authority is to remain in effect until revoked by me by providing you a 30-day written notice. I agree that you shall be fully protected in honoring any such debit. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance.
NOTE: Should your withdrawal not be honored by your bank, you will automatically be removed from Monthly Checking Account Automatic Premium Payment and will be billed monthly. **You will incur a service charge for any withdrawal not honored.**

Authorized Signature (as it appears in the financial institution's records)	Account Holder Name (please print)	Date
X		

B. Electronic Check – In lieu of sending a Paper Check, we can submit this same information electronically. We will need you to complete the information below. We require an exact amount and check number of the check you are using. Please void this check to prevent future use.

Account Holder Name (please print)	Bank Routing Number	Account Number	Check Number	Amount
				$

C. Credit/Debit Card – As a convenience to me, I request and authorize Anthem Blue Cross to charge my card for a one time initial debit upon approval. I understand that if this option is selected, **my account will be debited one month of premium as soon as the day of approval**. I understand that the initial payment amount may vary as a result of change(s) during underwriting and/or subsequent payment amounts may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents or moving my residence. I agree that you shall be fully protected in honoring any such card payments. I further agree that if any such card payment be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever, including any fees imposed by my bank, should my card be rejected even though such dishonor results in forfeiture of coverage. **We accept Visa and MasterCard.**

Card Number	Expiration Date	Cardholder ZIP Code
	/	–

Authorized Signature (as it appears on the credit card)	Cardholder Name (as it appears on the credit card – Please Print)	Date
X		

* When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use this information from your check to make an electronic fund transfer, funds will be withdrawn from your account as soon as the day of approval, and you will not receive your check back from your financial institution.

Anthem Blue Cross
Health. Join In.℠

Enrollment Form for California Individual Conversion Plans

Conversion ClearProtection Plus 5000 is offered by Anthem Blue Cross Life and Health Insurance Company.
PPO Share $7500 Conversion is offered by Anthem Blue Cross.

Current ID Numbers: Group No. | ID No.

IMPORTANT: To be eligible for conversion, you MUST return this enrollment application within 63 days of the end of your coverage. PREMIUM PAYMENT IS REQUIRED TO BE SUBMITTED WITH YOUR APPLICATION. Please complete the Conversion Application Payment Form and send it with your completed enrollment application. Applications received with no premium payment will be returned which may impact your eligibility for coverage. If you have any questions, please call 1-800-333-0912.

1. Enrollee Information

Please print in blue or black ink.

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

2. Choice of Individual Coverage

Choose one plan per enrollment form.

☐ Conversion ClearProtection Plus 5000 (OJTW)
(only available if your prior group coverage was offered by Anthem Blue Cross Life and Health Insurance Company)

☐ PPO Share $7500 Conversion (OJTX)
(only available if your prior group coverage was offered by Anthem Blue Cross)

Mailing Address (If different than above) or P.O. Box, Private Mail Box (PMB) No.	Daytime Phone No. ( )	Fax No. ( )
City / State / ZIP Code	County *(Required)*	Marital Status ☐ Single ☐ Married ☐ Domestic Partnership
Email Address	If possible, do you want e-mail notification? ☐ Yes ☐ No (This information will not be shared with any third party.)	

Applicant/Spouse Maiden Name

Has any person listed on this application lived (not traveled) outside the U.S. for the past three (3) consecutive months? ☐ Yes ☐ No
If Yes, who? _____ Are all applicants listed on this application legal residents of the United States and residents of the state in which you are applying for coverage? ☐ Yes ☐ No If No, who?_____

Language Choice *(Optional)* ☐ English (ENG) ☐ Korean (KOR) ☐ Spanish (SPA) ☐ Chinese (ZHO) (C/M)
☐ Vietnamese (VIE) ☐ Tagalog (TGL) ☐ Other (W09) _____

*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 above. This will not impact rights you may have to invoke a separate Confidential Communication under the Health Insurance and Portability and Accountability Act ("HIPAA").

3. Family Members Enrolling

Please list ALL eligible family members enrolling.

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

Relation	Last Name	First Name	M.I.	Social Security or ID No.	Birthdate	Age
10 ☐ Male 20 ☐ Female	Yourself					
30 ☐ Husband 40 ☐ Wife	Spouse**					
☐ Son ☐ Daughter						
☐ Son ☐ Daughter						
☐ Son ☐ Daughter						
☐ Son ☐ Daughter						

**Spouse includes domestic partner (when applicable). My domestic partner, if applicable, is only eligible for coverage if he or she has established a domestic partnership with me pursuant to California law.

4. Eligibility

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 only be considered and applied to the individual in question.

A. Did all enrollees listed on this application lose their most recent coverage as a result of the termination of coverage under a fully insured Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company employer-sponsored group health plan by the subscriber's employer/former employer? ☐ Yes ☐ No

If yes, all enrollees may be eligible for this policy (subject to other eligibility provisions). **If no** for any enrollee listed on this application, then he/she is not eligible for this Conversion plan.

B. Have all enrollees listed on this application been continuously covered during the three-month period immediately proceeding the termination of the Anthem Blue Cross or Anthem Blue Cross Life and Health employer-sponsored group health plan coverage that ended within the last 63 days? ☐ Yes ☐ No

If yes, please attach a Certificate of Creditable Coverage provided by your former employer or carrier OR a letter from the employer/former employer stating the effective date and the termination date of coverage or other documentation.
If no, any enrollee listed on this application is not eligible for this Conversion plan.

C. Is any enrollee currently covered by or eligible for Medicaid, Medicare (including coverage solely for end stage renal disease) or any other employer-sponsored health insurance benefits, or does any enrollee have similar benefits under an individual policy or contract? ☐ Yes ☐ No

If yes for any enrollee, then he/she is not eligible for these Conversion plans.

5. Conditions of Enrollment – IMPORTANT: To the best of my information and belief, I, the applicant, am solely responsible to review and attest to the completeness and validity of information provided on this enrollment form. It is important that you carefully read and fully understand the following:

Effective date requested: If your application is approved your coverage can start on any day of the month after we receive your application. The requested effective date is not a guarantee that the effective date will be the requested date in the event we agree to provide coverage.

Please choose the date you would like your coverage to start:
___/___/_____ MM/DD/YYYY

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.

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.

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 enrollment form if I do not qualify, and if so, I will not have any coverage. No coverage comes into effect unless and until Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company processes this enrollment form and notifies me in writing. The effective date of my coverage, if this enrollment form is accepted, will be assigned by Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company at its discretion.
2. Even if I pay money with this enrollment form, that money is only a deposit against future premium if this enrollment form is accepted. Cashing my check does not mean my enrollment form is processed. If this enrollment form is declined, neither Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company nor any affiliated company shall have any liability to me or anyone else listed on it. If this enrollment form is not accepted, neither I nor anyone listed on it will be entitled to benefits or coverage from Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company.
3. 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.
4. If the enrollee is a minor, I accept full legal and financial responsibility for the coverage and information provided on this enrollment form. (Court documents establishing guardianship must be submitted if the responsible adult is not the parent.)
5. 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 enrollee if the enrollment form is not approved, and neither shall any coverage exist nor shall the enrollee be entitled to any benefits unless and until this enrollment form is approved by the Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company.
6. 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/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.
7. ☐ 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 enrollment form. 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. 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.

5. Conditions of Enrollment - continued

To the best of my information and belief, I have personally read and attest to the completeness and validity of the information provided on this enrollment form. If I am accepted, this enrollment form 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 enrollment form has been interpreted (a signed Statement of Accountability must be attached, see Section 6), all persons applying for coverage agree that they have personally answered all questions directed to them. If an enrollee does not read English, the interpreter must sign and submit a Statement of Accountability for interpreting this entire enrollment form (see Section 6).

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.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO JURY OR COURT TRIAL.

Signatures (required) **– IMPORTANT: All applicants age 18 or over must personally read, agree to, sign and date this enrollment form.**

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

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

6. Statement of Accountability

Complete when the enrollee cannot fill out the enrollment form for Conversion coverage.

I, _____, have personally read and completed this enrollment form for the enrollee named below because:

☐ Enrollee does not read English ☐ Enrollee does not speak English ☐ Enrollee does not write English

☐ Enrollee 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 "Conditions of Enrollment."

Signature of Interpreter *(required)*	Today's Date (required)
X	

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

Language interpreted (e.g. Spanish):

Mailing Address

Please return this enrollment form to:

Anthem Blue Cross/Anthem Blue Cross Life
and Health Insurance Company
P.O. Box 9051
Oxnard, CA 93031-9051

Anthem Blue Cross
Health. **Join In.**℠

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This brochure provides a brief summary of benefits and services. If there is any difference between this brochure and the Policy/Evidence of Coverage (EOC), the Policy/EOC will prevail.

The plan benefits in this brochure comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to the Policy/EOC.