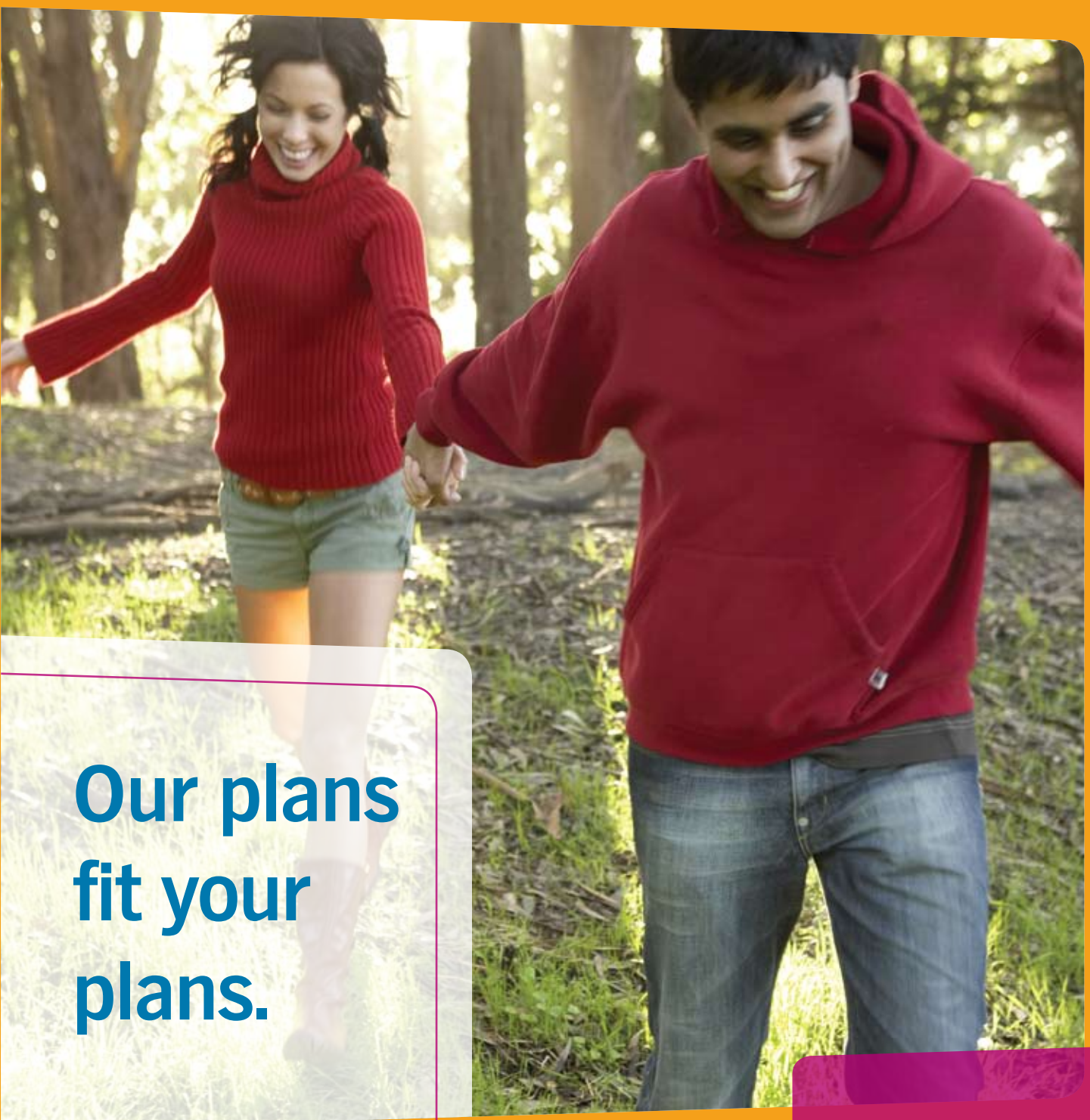
Anthem Blue Cross

INDIVIDUAL AND FAMILY
HEALTH CARE PLANS FOR CALIFORNIA



Our plans fit your plans.

SmartSense Basic PPO

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What makes Anthem Blue Cross plans a smart choice?

1. **A choice of plans to fit your budget.** No matter where you are in life, we have a plan that will fit your health care needs, as well as your budget.
2. **One of the largest networks in California.** With more than 50,000 PPO doctors and nearly 400 hospitals throughout the state, the chances are that your doctor is one of ours. And all our network providers have lower rates for our members, so your share of medical costs will be less.
3. **Coverage that travels with you.** No matter where life takes you — whether it's around the state or across the country — Anthem Blue Cross has you covered.
4. **Dental and life insurance.** To enhance your health and financial future, we also offer dental and term life coverage.
5. **Peace of mind.** You can relax knowing that we have been providing health care coverage and security to Californians for more than 70 years. We're committed to simplifying your life and improving your health.

- SmartSense
- Basic PPO

What's a PPO plan?

With a PPO (preferred provider organization) health care plan, you'll pay a lower share of your medical expenses when you use doctors or hospitals that participate in our PPO network. Your share of expenses includes:

- **Deductible:** Typically this is the amount you have to pay each calendar year for services that your health care plan covers before the plan begins paying. Please note that some plans may not have a deductible or may cover certain services before the deductible is met.
- **Coinsurance:** After your annual deductible is met, this is the percentage of the cost for which you will be responsible for services that your plan covers.

The amount of your deductible and coinsurance depends on which PPO plan you choose. A PPO plan will also pay a portion of the cost for services you may receive from non-participating (non-network) providers, but your share of the cost can be significantly higher.

Is your doctor in our network?
Go to anthem.com/ca > "Find a Doctor."

Plan highlights

SmartSense	Basic PPO
One of our lowest priced plans yet provides solid protection that covers the essentials.	**This low cost plan provides basic and catastrophic coverage plus emergency services.**
Features: · First three doctor visits covered before the deductible · Choice of two prescription drug coverage options: Comprehensive or Generic Only · Fourth quarter deductible carryover (Any expenses incurred in the 4th quarter that apply toward the deductible will carry over to the following calendar year, as long as the entire deductible was not all met in the 4th quarter)	**Features:** · Some preventive screenings covered before the deductible · Hospital coverage in the event of a catastrophic illness or injury
You should know: · After the first three doctor visits, all other visits are covered after the deductible · Maternity benefits are not included with this plan	**You should know:** · Doctors' office visits are covered once you meet your annual out-of-pocket limit · Prescription drugs are not covered unless you're hospitalized · Maternity benefits are not included with this plan

See the next two pages for more details about these plans

Prescription drug coverage (available with SmartSense)

The cost of prescription drugs can be staggering and is one of the leading causes of rising health care costs. To help control your share of the costs, some of our plans include options for prescription drug coverage.

As you'll see on the following pages, our SmartSense plan gives you a choice of Comprehensive prescription drug coverage (generic and brand-names) or generics only. It's important to note that the Basic PPO only covers prescription drugs if you are hospitalized.

Even if you choose the SmartSense plan with Comprehensive prescription drug coverage, it's still a good idea to consider using generic drugs for the best value. Generic drugs have the same active ingredients as their brand-name equivalents, but normally cost less.

Plan Benefits		SmartSense®		Basic PPO	
		In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible Choices	Individual	$500 / $1,500 / $2,500 / $5,000	$5,000	$1,000 / $2,500 per member Inpatient or surgical procedures only	
	Family	$1,000 / $3,000 / $5,000 / $10,000	$10,000	Each family member has an individual deductible. Once 2 members each reach the deductible, the deductible is satisfied for the entire family	
		Each family member has an individual deductible. The family deductible can be satisfied by 2 or more members.			
Annual Out-of-Pocket Limit[1] *(in addition to deductible)*	Individual	$2,500	$10,000	$2,500 / $2,500 per member	
	Family	$5,000	$20,000	Each family member has an individual out-of-pocket limit. Once 2 members each reach the out-of-pocket limit, the limit is satisfied for the entire family	
		Each family member has an individual out-of-pocket limit. The family out-of-pocket limit can be satisfied by 2 or more members.			
Lifetime Maximum		Plan pays up to $7 Million per member		Plan pays up to $5 Million per member	

Covered Services The amounts shown are your share of costs *after any deductible*	In-Network	Out-of-Network	In-Network	Out-of-Network
Doctors' Office Visits	$30 copay for first 3 visits per member per year (*deductible waived);* after 3 visits and once deductible is met, then 30% of negotiated fee	50% of negotiated fee plus all excess charges	No office visit benefit until out-of-pocket max is met, then you pay $0 of negotiated fee	No office visit benefit until out-of-pocket limit is met, then you pay 50% of the negotiated fee, plus all excess charges
Professional Services *(x-ray, lab, anesthesia, surgeon, etc.)*	30% of negotiated fee	50% of negotiated fee plus all excess charges	20% of negotiated fee for inpatient or surgical procedures only. No office visit benefit until out-of-pocket limit is met, then you pay $0 of negotiated fee	50% of negotiated fee, plus all excess charges, for covered inpatient or surgical procedures only.
Hospital Inpatient *(overnight hospital stays)*	30% of negotiated fee	All charges except $650 per day	20% of negotiated fee[2]	All charges except $650 per day
Hospital Outpatient *(if you don't stay overnight)*	30% of negotiated fee	All charges except $380 per day	20% of negotiated fee[2]	All charges except $380 per day

Emergency Room Services *($100 copay applies for each visit; waived if admitted as inpatient)*	30% of negotiated fee	50% of customary and reasonable fees plus all excess charges	20% of negotiated fee	20% of customary and reasonable fees plus all excess charges
Maternity	not covered		not covered	
Preventive Care *(tests ordered by physician are covered, including appropriate screening for breast, cervical, ovarian, and prostate cancer)*	Annual physical exam(s): 30% of negotiated fee OR HealthyCheck℠ Centers: $25 / $75 copay for basic/premium screening (deductible waived) Routine mammogram, Pap and PSA tests: 30% of negotiated fee Children's Services: 30% of negotiated fee	50% of negotiated fee plus all excess charges.	HealthyCheck℠ Centers: $25 / $75 copay for basic/premium screening *(deductible waived)* Routine mammogram, Pap and PSA tests: 20% of negotiated fee *(deductible waived)*	Routine mammogram, Pap and PSA tests: 50% of negotiated fee plus all excess charges *(deductible waived)*
Chiropractic Services	30% of negotiated fee	50% of negotiated fee plus all excess charges	Not covered unless during inpatient admission	
	Plan covers up to $500 per year			

Prescription Drug Coverage	In-Network	Out-of-Network	In-Network	Out-of-Network
Comprehensive Prescription Drug Coverage	**Generic:** $15 copay *(or 40%, whichever is greater)*	**Generic:** $15 copay *(or 40%, whichever is greater)*	not covered	
	Brand-name/Specialty $500 annual deductible (2 member max) applies before the following: **Brand-name:** $15 copay *(or 40%, whichever is greater, not to exceed $500 per prescription)* **Specialty:** 40% **$4,500 Annual Out-of-Pocket Maximum *(the most you'll have to pay)*** In-network only and in addition to brand-name/specialty deductible	**$500 annual brand-name deductible (2 member max) applies before the following:** **Brand-name:** $15 copay *(or 40%, whichever is greater)* **Specialty:** not covered		
Generic Prescription Drug Coverage	$15 copay *(or 40%, whichever is greater)*		not covered	

1 Excludes non-participating charges in excess of the 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 the annual calendar year out-of-pocket limit except where specifically noted in the policy.

2 Additional $500 admission charge at participating hospitals (no additional charge for preferred participating) is for inpatient stays or outpatient surgery or infusion therapy. The charge is not required for ambulatory surgical centers or medical emergencies.

Give yourself every advantage... good health, a bright smile and financial security.

Why dental coverage?

Dental care can play an important role in your overall health. Regular checkups and cleanings can help detect the early signs of oral health problems, reduce the risk of permanent damage to your teeth and gums, and prevent costly treatments down the road.

Dental Blue® PPO Plans feature:

- One of the largest Dental PPO networks in the state (more than 21,000 dental locations)
- No deductibles for cleanings, exams and x-rays
- Savings on popular services like veneers, dental implants and braces
- Negotiated discounts on services during any waiting periods and after you reach your annual maximum

The Dental Blue PPO plans give you the flexibility to see any dentist, although your costs will usually be less when you see a dentist in the network.

Dental SelectHMO Plans feature:

- A network of more than 4,800 dentists to choose from
- No deductibles and a low $5 copay for exams, cleanings and x-rays
- Coverage for orthodontic services
- No annual maximums and no waiting periods for most services

The Dental SelectHMO network is not available in all counties so ask your agent for more details.

Why term life insurance?

Losing a loved one is hard enough without having to worry about financial obligations. Families are often unprepared for this sudden loss, and term life insurance can provide financial support and peace of mind at a difficult time.

Here are just a couple of reasons why you'll want to purchase term life insurance from Anthem Blue Cross Life and Health Insurance Company:

- It's inexpensive – just pennies a day
- It's easy – no additional forms are required to enroll

Term life monthly rates

Age	$15,000 Benefit	$30,000 Benefit	$50,000 Benefit	$75,000 Benefit	$100,000 Benefit
1-18	$1.50	$3.00	N/A	N/A	N/A
19-29	$2.80	$5.60	$9.30	$11.25	$13.00
30-39	$3.25	$6.50	$10.80	$13.50	$16.00
40-49	$7.50	$15.00	$25.00	$33.75	$42.00
50-59	$20.90	$41.80	$69.60	$97.50	$125.00
60-64	$29.40	$58.80	$98.00	$142.50	$185.00

For more information on our dental plans or life insurance, ask your Anthem Blue Cross agent today!

What Individual health care plans do not cover

The following Exclusions and Limitations will help you understand what your health care plan does not include before you enroll. These listings are an overview only. For a comprehensive list of the plans' exclusions and limitations, you can request a copy of a Policy/Combined Evidence of Coverage and Disclosure Form (EOC) booklet. Just ask your agent or contact Anthem Blue Cross.

Exclusions and Limitations

- Maternity or pregnancy care.
- Acupuncture/Acupressure
- 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 Policy/EOC.
- Services received before your effective date or 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), except as specifically stated in the Policy/EOC.
- Any amounts in excess of the maximum amounts listed in the Policy/EOC.
- 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/EOC.
- Hearing aids.
- Contraceptive drugs and/or certain contraceptive devices, except as specifically stated in the Policy/EOC.
- Infertility services.
- Private duty nursing.
- Eyeglasses or contact lenses, except as specifically stated in the Policy/EOC.
- Vision care including certain eye surgeries to replace glasses, except as specifically stated in the Policy/EOC.
- Mental and nervous disorders and substance abuse, except as specifically stated in the Policy/EOC.
- Certain orthopedic shoes or shoe inserts, except as specifically stated in the Policy/EOC.
- Services or supplies related to a preexisting condition.
- Outdoor treatment programs.
- Telephone or facsimile machine consultations.
- Educational services except as specifically provided or arranged by Anthem Blue Cross.
- Nutritional counseling or food or dietary supplements, except for formulas and special food products to prevent complications of phenylketonuria (PKU).
- Care or treatment furnished in a non-contracting hospital, except as specifically stated in the Policy/EOC.
- Personal comfort items.
- Custodial care.
- Certain genetic testing.
- Outpatient speech therapy, except as specifically stated in the Policy/EOC.
- Any amounts in excess of maximums stated in the Policy/EOC.
- Outpatient drugs, medications or other substances dispensed or administered in any outpatient setting.
- Services or supplies provided to any person not covered under the Agreement in connection with a surrogate pregnancy.

Additional exclusions and limitations for Basic PPO:

- Preventive benefits, except for Pap and PSA tests, and mammograms not specifically listed in the Policy.
- Physician office visits and associated costs, except as specifically described in the Policy.
- Physical or occupational therapy or chiropractic services, except those provided during an inpatient hospital confinement.

Incurred medical care ratio

As required by law, we are advising you that Anthem Blue Cross and its affiliated companies incurred medical care ratio for 2007 was 80.43 percent. This ratio was calculated after provider discounts were applied.

Waiting periods

There is a specific six-month waiting period for coverage of any condition, disease or ailment for which medical advice or treatment was recommended or received within six months preceding the effective date of coverage. If you apply for coverage within 63 days of terminating your membership with another "creditable" health care plan, then you can use your prior coverage for credit toward the six-month waiting period. Anthem Blue Cross will credit the time you were enrolled on the previous plan. Consult with your Anthem Blue Cross agent or representative if you have a question about the underwriting process.

Ready to Enroll?

Call your Anthem Blue Cross Agent today!

To enroll, you and your dependents must be:

- Age 64 ¾ or younger;
- A permanent legal resident of California;
- A U.S. resident for at least the last 3 months;
- The applicant's spouse or domestic partner, age 64 ¾ or younger;
- The applicant's children (under 19 years of age), or the children (under 19 years of age) of the applicant's enrolling spouse or qualified domestic partner;
- The applicant's unmarried dependent children between the ages of 19 through 22 ("dependent" as defined by the Internal Revenue Service);
- 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 is chiefly dependent upon the applicant for support and maintenance.

Medical underwriting requirement

We believe that the cost of our plans should be consistent with your expected health care needs and risk factors. That's why Anthem Blue Cross offers various levels of coverage. To determine individual medical risk factors, all applications are subject to medical underwriting. Depending on the results of the underwriting review, a number of things may happen:

- You may be offered coverage at the standard premium charge, or
- You may be offered the plan you selected at a higher rate, or
- You may not qualify for the plan listed in this brochure, or
- You may be offered an alternate plan.

If you have a significant medical condition and do not qualify for the plan you've chosen from this brochure or if you have discontinued group coverage, please contact your Anthem Blue Cross representative for information regarding other Individual coverage options.

No-obligation review period

After you enroll in a plan offered by Anthem Blue Cross, you will receive a Policy/EOC booklet that explains the exact terms and conditions of coverage, including the plan's exclusions and limitations. You will have 10 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 agent or Anthem Blue Cross.

Anthem® Blue Cross®

This brochure provides a brief summary of benefits and services.
If there is any difference between this brochure and the Policy, the Policy will prevail.