Summary of Features

Anthem Blue Cross

AFFORDABLE PROTECTION

Small Group EmployeeElect Saver PPO Plan

Helping you stay healthy all year long

MCASB2182CEN Rev. 12/08)

Solid protection
Affordable prices

Saver PPO: one of our most affordable PPO plan offers peace of mind with valuable hospital coverage

It's all about you.

- You get up to $5,000,000 in covered benefits over your lifetime
- You choose from over 53,000 doctors and specialists, and from over 400 hospitals
- You save money because we've negotiated lower rates with our in-network doctors
- You benefit from a HealthyCheck℠ preventive screening each year
- You get emergency care covered while traveling across the U.S. and throughout the world, 24/7

Your plan is packed with valuable programs and services.

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

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

360° Health offers:

1 *Level one starts with education plus key tools and discounts to maximize your health care dollars.* **Health Tools and Resources**
From our website, and through MyHealth@Anthem®, powered by *Web*MD®, you get access to easy-to-use, personalized online tools and trusted health information to help you make more informed health care decisions. Our online lifestyle centers can point you to the health information that matters most to you.

And, our SpecialOffers program includes discounts on health and wellness products and certain alternative medicine services, plus access to online health programs.

2 *The second level offers guidance so you can get help when you need care or it can simply help you achieve your wellness goals.* **Health Guidance**
Our 24/7 NurseLine offers access to qualified registered nurses anytime to help you decide whether a problem requires medical attention so you can get the appropriate level of care and avoid unnecessary worry. Programs like MyHealth Assessment help you take an honest look at your health, plus there are tools to help guide you as you make important care decisions.

3 *And finally, assistance for members with challenging health needs.* **Health Management**
Members with acute or chronic health conditions like asthma, diabetes, coronary artery disease, chronic obstructive pulmonary disease and heart failure get an additional, specialized level of support.

We're dedicated to improving your health.

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

Have a question? Just call Small Group Customer Service at 800-627-8797 and we'll be happy to help.

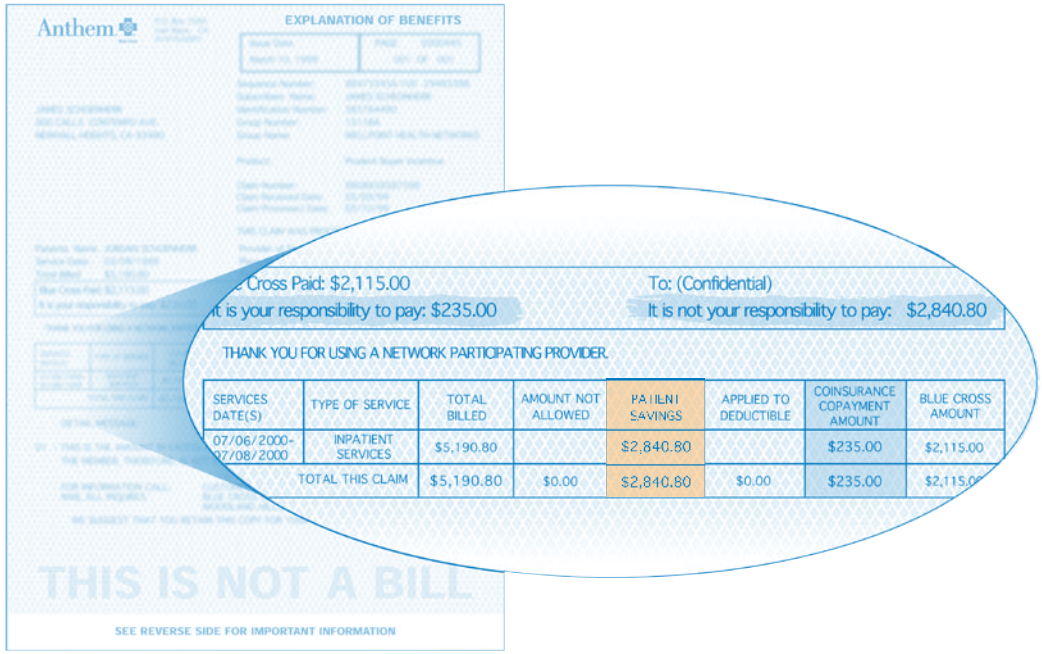
Coverage you can trust. Low premiums and peace of mind with valuable hospital coverage with some limited professional services. That's what makes our Saver PPO Plan Affordable Protection.

You're free to go to health care providers outside of the Anthem Blue Cross network, but you'll save a substantial amount by choosing from our 53,000 doctors and 400 hospitals. Staying in the Anthem Blue Cross network will help you get maximum value from your health care benefits — and from your health care dollar.

Powerful savings from Anthem Blue Cross

With Anthem Blue Cross health coverage, you save in three significant ways:

1. Our in-network doctors and hospitals charge you lower, Anthem Blue Cross-negotiated fees
2. Our BlueCard program gives you access to in-network providers at discounted rates all across the country
3. You pay only a portion of the fees for your eligible covered expenses (see example below) and we pay the rest, after your deductible


Anthem

EXPLANATION OF BENEFITS

Cross Paid: $2,115.00 To: (Confidential)

t is your responsibility to pay: $235.00 It is not your responsibility to pay: $2,840.80

THANK YOU FOR USING A NETWORK PARTICIPATING PROVIDER.

SERVICES DATE(S)	TYPE OF SERVICE	TOTAL BILLED	AMOUNT NOT ALLOWED	PAIDNT SAVINGS	APPLIED TO DEDUCTIBLE	COINSURANCE COPAYMENT AMOUNT	BLUE CROSS AMOUNT
07/06/2000-07/08/2000	INPATIENT SERVICES	$5,190.80		$2,840.80		$235.00	$2,115.00
	TOTAL THIS CLAIM	$5,190.80	$0.00	$2,840.80	$0.00	$235.00	$2,115.00

THIS IS NOT A BILL

SEE REVERSE SIDE FOR IMPORTANT INFORMATION

This is an example only. Your savings may vary based on your plan and services received.

Small Group Saver PPO Plan

All amounts listed are the member's responsibility to pay after deductible(s), unless otherwise noted.
In-network negotiated fees can result in 30 to 40% savings compared to providers' usual fees.

CORE FEATURES	IN-NETWORK Receive Negotiated Savings	OUT-OF-NETWORK Pay Higher Costs
Annual Deductible	Covered hospital benefits and initial professional services[2]: $500 per member, 2-member maximum Subsequent professional services with continued access to Anthem Blue Cross in-network savings: 100% of negotiated fee up to $5,000 per member, 2-member maximum[3]	
Maximum Lifetime Covered Charges Paid by Anthem Blue Cross In-network and out-of-network combined	$5,000,000	
Annual Out-of-Pocket Maximum[1]	Covered hospital benefits and initial professional services[2]: $2,000 per member, 2-member maximum, includes deductible (in-network and out-of-network combined) Subsequent professional services with continued access to Anthem Blue Cross in-network savings: $5,000 per member[3]	
Office Visits Each year, the first 2 visits per adult and first 4 visits per child (in-network and out-of-network combined) are not subject to deductible	Initial 2 visits per adult/4 per child (in-network and out-of-network combined): $20 copay, deductible waived Additional visits, with continued access to Anthem Blue Cross savings: 100% of negotiated fee[3]	Initial 2 visits per adult/4 per child (in-network and out-of-network combined): 50% of negotiated fee, plus 100% of excess charges, deductible waived Additional visits: 100% of negotiated fee, plus all excess charges[3]
Diagnostic Lab and X-rays Each year, the first $500 of eligible charges per member (in-network and out-of-network combined) are not subject to deductible	Covered services including maternity: 20% of negotiated fee Diagnostic lab & X-rays: 20% of negotiated fee (up to a maximum $500 Anthem Blue Cross payment in-network and out-of-network combined); then member pays 100% of negotiated fee with continued access to Anthem Blue Cross savings[3]	Covered services including maternity: 50% of negotiated fee, plus 100% of excess charges Diagnostic lab & X-rays: 50% of negotiated fee, plus 100% of excess charges (up to a maximum $500 Anthem Blue Cross payment in-network and out-of-network combined); then member pays 100% of negotiated fee, plus all excess charges[3]
Hospital Inpatient Facility Services Pre-service Review required	**20%** of negotiated fee after $500 deductible	All charges in excess of $650 per day after $500 deductible
Hospital Inpatient Professional Services (lab, physician, anesthesia)	**20%** of negotiated fee after $500 deductible	**50%** of negotiated fee, plus **100%** of excess charges after $500 deductible
Outpatient Facility Services Includes surgery, medical emergency, radiation therapy and infusion therapy Pre-service Review required for certain surgical services and diagnostic procedures	**20%** of negotiated fee after $500 deductible	All charges in excess of $380 per day after $500 deductible
Outpatient Professional Services Related to covered hospital charges	**20%** of negotiated fee after $500 deductible	**50%** of negotiated fee, plus **100%** of excess charges after $500 deductible
Ambulatory Surgical Centers Pre-service Review required	**20%** of negotiated fee after $500 deductible	All charges in excess of $380 per day after $500 deductible
Prescription Drugs[4] 30-day supply retail; up to a 60-day supply available through mail order (amounts shown apply to each 30-day supply) Maximum Anthem Blue Cross payment of $500 per member, in-network and out-of-network combined. Continued access to Anthem Blue Cross pharmacy discounts after maximum is reached	***Not subject to annual deductible*** Generic: **$10** copay Brand-name Drugs: If generic not available: **$25** copay If generic is available: **$10** copay, **plus** the difference in cost between brand-name drug and generic-equivalent. Self-injectable (except insulin): **30%** of negotiated fee	***Not subject to annual deductible*** **50%** of drug limited fee schedule plus **100%** of excess charges if filled within California
HealthyCheck℠ Screenings, Ages 7-Adult Includes certain lab tests, immunizations and health education information	***Not subject to annual deductibles*** **$25** or **$75** copay health screening options	Not available

1 Amounts that do not apply to the annual out-of pocket maximum include, but are not limited to: annual deductible; copay paid under the pharmacy benefit; copay for not obtaining pre-service review; non-covered services; charges exceeding Anthem Blue Cross' payment amount; charges that exceed annual or lifetime maximums.

2 $500 deductible applies to hospital inpatient facility and professional services, hospital outpatient surgery, medical emergency, radiation therapy, hemodialysis treatment, infusion therapy, acupuncture/acupressure, professional services related to covered hospital outpatient surgical services, ambulance, skilled nursing facility stays, home health care, and covered mental health services (see note 3 about separate $5,000 deductible).

3 $5,000 deductible (separate from $500 deductible) begins to accumulate after annual initial office visits - 2 per adult/4 per child - are used, and after initial maximum diagnostic lab and X-rays benefits are paid by the plan (see Certificate for details); once a member meets the $5,000 deductible, then office visits, diagnostic lab and X-rays charges and additional eligible covered expenses are covered at 100% of eligible charges. Once two members of a family meet the $5,000 deductible, the entire family is covered at 100% of eligible charges.

4 If a member selects a brand-name drug when a generic-equivalent drug is available, even if the physician writes a "dispense as written" or "do not substitute" prescription, the member will be responsible for a generic copay plus the difference in cost between the brand-name drug and the generic-equivalent drug.

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

ADDITIONAL FEATURES	IN-NETWORK Receive Negotiated Savings	OUT-OF-NETWORK Pay Higher Costs
Well-Baby Immunizations and Adult Screening Tests **Children through age 6** Regular check-up and immunizations **Ages 7-Adult** Includes annual Pap, breast exam, and mammogram for women, and Prostate Specific Antigen study for men	***Not subject to annual deductibles*** **20%** of negotiated fee	***Not subject to annual deductibles*** **50%** of negotiated fee, plus **100%** of excess charges
Emergency Care **$100** Emergency Room copay for each visit - waived if admitted	**20%** of negotiated fee after $500 deductible	**20%** of customary and reasonable charges, plus **100%** of excess charges for first 48 hours after $500 deductible; after 48 hours, all charges in excess of $650 per day after $500 deductible
Ambulance $750 per trip maximum Anthem Blue Cross payment	**20%** of negotiated fee, plus **100%** in excess of $750 per trip maximum up to the negotiated amount, after $500 deductible	**50%** of customary and reasonable charges plus **100%** of excess charges after $500 deductible
Skilled Nursing Facility 100 days per year, in-network and out-of-network combined Pre-service Review required	**20%** of negotiated fee, plus **100%** in excess of $540 per day maximum up to the negotiated amount, after $500 deductible ($540 per day maximum Anthem Blue Cross payment)	All charges in excess of $380 per day after $500 deductible
Home Health Care 100 four-hour visits per year, $137.50 per visit maximum Anthem Blue Cross payment, in-network and out-of-network combined Pre-service Review required	**20%** of negotiated fee, plus **100%** in excess of $137.50 per visit maximum up to the negotiated amount, after $500 deductible	**50%** of customary and reasonable charges plus **100%** of charges in excess of $137.50 per visit maximum after $500 deductible
Physical/Occupational Therapy, Chiropractic Care	Not covered	Not covered
Acupuncture/Acupressure 24 visits per year, in-network and out-of-network combined	All of the negotiated fee in excess of $25 per visit after $500 deductible	All charges in excess of $25 per visit after $500 deductible
Mental Health/Inpatient* Includes chemical dependency; 30 days per year, in-network and out-of-network combined Pre-service Review required	All of the negotiated fee in excess of $175 per day after $500 deductible	All charges in excess of $175 per day after $500 deductible
Mental Health/Outpatient Professional Services*	Not covered	Not covered
Infusion Therapy Includes chemotherapy Pre-service Review required	**20%** of negotiated fee after $500 deductible	**50%** of negotiated fee, plus **100%** of charges in excess of $50 per day for all infusion therapy expenses except drugs; all charges in excess of the average wholesale price for all infusion therapy drugs; all charges in excess of the combined maximum Anthem Blue Cross payment of $500 per day; after $500 deductible
Infertility Services Maximum lifetime Anthem Blue Cross payment $2,000, in-network and out-of-network combined	**20%** of negotiated fee after $500 deductible	Inpatient facility services: Member pays all charges in excess of $650 per day after $500 deductible Outpatient facility services: Member pays all charges in excess of $380 per day after $500 deductible Professional services related to covered hospital charges: 50% of negotiated fee, plus 100% of excess charges after $500 deductible

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

Exclusions and Limitations

Following is an abbreviated list of exclusions and limitations; please see the Certificate for comprehensive details.

- Any amounts in excess of maximums stated in the Certificate.
- Services or supplies that are not medically necessary.
- Services received before your effective date.
- Services received after your coverage ends.
- Any conditions for which benefits can be recovered under any workers' compensation law or similar law.
- Services you receive for which you are not legally obligated to pay.
- Services for which no charge is made to you in the absence of insurance coverage.
- Services not listed as covered in the Certificate.
- Services from relatives.
- Vision care except as specifically stated in the Certificate.
- Eye surgery performed solely for the purpose of correcting refractive defects.
- Hearing aids and routine hearing tests except as specifically stated in the Certificate.
- Sex changes.
- Dental and orthodontic services except as specifically stated in the Certificate.
- Cosmetic surgery.
- Routine physical examinations except as specifically stated in the Certificate.
- Treatment of mental or nervous disorders and substance abuse (including nicotine use) or psychological testing, except as specifically stated in the Certificate.
- Custodial care.
- Experimental or investigational services.
- Services provided by a local, state or federal government agency, unless you have to pay for them.
- Diagnostic admissions.
- Telephone or facsimile machine consultations.
- Personal comfort items.
- Nutritional counseling.
- Health club memberships.
- Any services to the extent you are entitled to receive Medicare benefits for those services without payment of additional premium for Medicare coverage.
- Food supplements, except for formulas and special food products to prevent complications of phenylketonuria (PKU).
- Genetic testing for non-medical reasons or when there is no medical indication or no family history of genetic abnormality.
- Outdoor treatment programs.
- Replacement of prosthetics and durable medical equipment when lost or stolen.
- Any services or supplies provided to any person not covered under the Agreement in connection with a surrogate pregnancy.
- Immunizations for travel outside the United States.
- Services or supplies related to a pre-existing condition.
- Educational services except as specifically provided or arranged by Anthem Blue Cross.
- Infertility services (including sterilization reversal) except as specifically stated in the Certificate.
- Care or treatment provided in a non-contracting hospital.
- Private duty nursing except as specifically stated in the Certificate.
- Services primarily for weight reduction except medically necessary treatment of morbid obesity.
- Outpatient drugs, medications or other substances dispensed or administered in any outpatient setting.
- Contraceptive devices unless your physician determines that oral contraceptive drugs are not medically appropriate.
- Physical and/or occupational therapy/ medicine or chiropractic services except as specifically stated in the Certificate.
- Outpatient speech therapy.
- Footwear except as specifically stated in the Certificate.

General Provisions

Member Privacy

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

Utilization Review

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

Grievances

All complaints and disputes relating to a member's coverage must be resolved in accordance with Anthem Blue Cross' grievance procedure. You can report your grievance by phone or in writing; see your Anthem Blue Cross ID card for the appropriate contact information. All grievances received by Anthem Blue Cross that cannot be resolved by phone (when appropriate) to the mutual satisfaction of the member and Anthem Blue Cross will be acknowledged in writing, together with a description of how Anthem Blue Cross proposes to resolve the grievance. Grievances that cannot be resolved by these procedures shall be resolved as indicated through binding arbitration, or if the plan you are covered under is subject to the Employee Retirement Income Security

Act of 1974 (ERISA), in compliance with ERISA rules. If the group is subject to ERISA, and a member disagrees with Anthem Blue Cross' proposed resolution of a grievance, the member may submit an appeal by phone or in writing, by contacting the phone number or address printed on the letterhead of the Anthem Blue Cross response letter.

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

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

Department of Insurance

Overseeing the industry and protecting the state's insurance consumers is the responsibility of the California Department of Insurance (CDI). The CDI regulates, investigates and audits insurance business to ensure that companies remain solvent and meet their obligations to insurance policyholders. If you have a problem regarding your coverage, please contact Anthem Blue Cross first to resolve the issue. If contacts between you (the complainant) and Anthem Blue Cross (the Insurer) have failed to produce a satisfactory solution to the problem, you may wish to contact the CDI. They can be reached by writing to the CDI Consumer Affairs Bureau 300 South Spring St. - South Tower, Los Angeles, CA 90013. The CDI also has a toll free phone number 800-927-HELP (4357) that you may call for assistance.

Binding Arbitration

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

Medicare

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

If Medicare is a member's primary health plan, Anthem Blue Cross will not provide benefits that duplicate any benefits you are entitled to receive under Medicare. This means that when Medicare is the primary health coverage, benefits are provided in accordance with the benefits of the plan, less any amount paid by Medicare. If you are entitled to Part A and B of Medicare, you will be eligible for non-duplicate Medicare coverage, with supplemental coordination of benefits. However, if you are required to pay the Social Security Administration an additional premium for any part of Medicare, then the above policy will only apply if you are enrolled in that part of Medicare. Note: Medicare-eligible employees/dependents enrolled in plans where Medicare is primary may obtain an Individual Anthem Blue Cross Medicare Supplement plan with the pre-existing condition exclusion waived.

Coordination of Benefits

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

Third-Party Liability

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

Voiding Coverage for False and Misleading Information

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

Incurred Medical Care Ratio

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

Anthem Blue Cross and its branded affiliate, Anthem Blue Cross Life and Health Insurance Company, are NCQA Accredited health plans.

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

Saver PPO Plan is offered by Anthem Blue Cross Life and Health Insurance Company.

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