



SUPERIOR DESIGNS

Small Group Employee Elect Premier PPO \$20 Copay Plan

Helping you stay healthy all year long

Small Group Premier PPO \$20 Copay 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 In-network and out-of-network combined, annual deductible applies toward annual out-of-pocket maximum	\$250 per member for all medical services except office visits, annual Physical Exam, HealthyCheck screenings and prescription drugs; two-member maximum	
Maximum Lifetime Covered Charges Paid by Anthem Blue Cross In-network and out-of-network combined	\$5,000,000	
Annual Out-of-Pocket Maximum¹ In-network and out-of-network maximums accumulate separately	\$3,000 per member, two-member maximum Certain member payments do not apply ¹	\$5,000 per member, two-member maximum
Office Visits Not subject to annual deductible	\$20 copay for initial 12 office visits per member, additional office visits 40% of negotiated fee	40% of customary and reasonable charges plus 100% of excess charges
Other Professional Services Includes maternity, diagnostic lab and X-rays	20% of negotiated fee after annual deductible	40% of customary and reasonable charges plus 100% of excess charges after annual deductible
Hospital Inpatient Facility Services Pre-service Review required	20% of negotiated fee after annual deductible	40% of customary and reasonable charges plus 100% of excess charges after annual deductible
Hospital Inpatient Professional Services (lab, physician, anesthesia)	20% of negotiated fee after annual deductible	40% of customary and reasonable charges plus 100% of excess charges after annual deductible
Outpatient Facility Services Pre-service Review required for certain surgical services and diagnostic procedures	20% of negotiated fee after annual deductible	40% of customary and reasonable charges plus 100% of excess charges after annual deductible
Ambulatory Surgical Centers Pre-service Review required	20% of negotiated fee after annual deductible	All charges in excess of \$540 per day after annual deductible
Prescription Drugs² 30-day supply retail; up to a 60-day supply available through mail order (amounts shown apply to each 30-day supply)	Generic: \$15 copay Brand-name Drugs: \$25 copay Self-injectable (except insulin): 30% of negotiated fee	40% of drug limited fee schedule plus 100% of excess charges if filled within California
Annual Preventive Care Options (not subject to deductible): each family member, ages 7-adult, may choose annually between physical exam or HealthyCheck screening.		
Physical Exam Maximum Anthem Blue Cross payment \$200 for members covered more than 6 months/\$100 if less; in-network and out-of-network combined	\$20 copay for office visit plus 20% of negotiated fee for all other covered services	40% of customary and reasonable charges plus 100% of excess charges
OR		
HealthyCheckSM Screening Includes certain lab tests, immunizations and health education information	\$25 or \$75 copay screening options	Not available

¹ Services that do not apply to the annual out-of-pocket maximum include, but are not limited to: copay paid under the pharmacy benefit; copay paid for acupuncture/ acupressure; copay for mental or nervous disorders and substance abuse (except for treatment of severe mental illness and serious emotional disturbances of a child); copay for not obtaining pre-service review; HealthyCheck payments; \$500 copay for infertility services; non-covered services.
² Infertility Drugs: Infertility drug lifetime maximum Anthem Blue Cross payment is \$1,500 in-network and out-of-network combined. All drugs: if member selects a brand-name drug when a generic-equivalent drug is available, and the physician does not write a "dispense as written" or "do not substitute" prescription, the member will be responsible for the brand-name copay plus the difference in cost between the brand-name drug and the generic-equivalent drug.

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

ADDITIONAL FEATURES	IN-NETWORK Receive Negotiated Savings	OUT-OF-NETWORK Pay Higher Costs
<p>Well-Baby Immunizations and Adult Screening Tests Children through age 6 Regular check-ups and immunizations</p> <p>Ages 7-Adult Includes annual Pap, breast exam and mammogram for women, and Prostate Specific Antigen study for men</p>	<p>\$20 office visit copay (not subject to deductible) plus 20% of negotiated fee for all other covered services after annual deductible</p>	<p>40% of customary and reasonable charges plus 100% of excess charges after annual deductible</p>
<p>Emergency Care \$100 Emergency Room copay for each visit - waived if admitted</p>	<p>20% of negotiated fee after annual deductible</p>	<p>20% of customary and reasonable charges, plus 100% of excess charges for first 48 hours after annual deductible; after 48 hours, 40% of customary and reasonable charges plus 100% of excess charges after annual deductible</p>
<p>Ambulance</p>	<p>20% of negotiated fee after annual deductible</p>	<p>40% of customary and reasonable charges plus 100% of excess charges after annual deductible (in a medical emergency)</p>
<p>Skilled Nursing Facility 100 days per year, in-network and out-of-network combined; Pre-service Review required</p>	<p>20% of negotiated fee after annual deductible</p>	<p>All charges in excess of \$150 per day after annual deductible</p>
<p>Home Health Care 100 four-hour visits per year, in-network and out-of-network combined; Pre-service Review required</p>	<p>20% of negotiated fee after annual deductible</p>	<p>All charges in excess of \$75 per visit after annual deductible</p>
<p>Physical/Occupational Therapy, Chiropractic Care 12 visits per year, in-network and out-of-network combined</p>	<p>20% of negotiated fee after annual deductible</p>	<p>All charges in excess of \$25 per visit after annual deductible</p>
<p>Acupuncture/Acupressure 24 visits per year, in-network and out-of-network combined</p>	<p>20% of negotiated fee after annual deductible</p>	<p>All charges in excess of \$25 per visit after annual deductible</p>
<p>Mental Health/Inpatient* Includes chemical dependency; 30 days per year, in-network and out-of-network combined; Pre-service Review required</p>	<p>All of negotiated fee in excess of \$175 per day after annual deductible</p>	<p>All charges in excess of \$175 per day after annual deductible</p>
<p>Mental Health/Outpatient Professional Services* Includes chemical dependency One visit per day, 20 visits per year, in-network and out-of-network combined</p>	<p>All of negotiated fee in excess of \$25 per visit after annual deductible</p>	<p>All charges in excess of \$25 per visit after annual deductible</p>
<p>Infusion Therapy Includes chemotherapy Pre-service Review required</p>	<p>20% of negotiated fee after annual deductible</p>	<p>All 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 annual deductible</p>
<p>Infertility Services Maximum lifetime Anthem Blue Cross payment \$2,000, in-network and out-of-network combined</p>	<p>\$500 copay plus 20% of the balance of negotiated fee after annual deductible</p>	<p>\$500 copay plus 40% of the balance of customary and reasonable charges plus 100% of excess charges after annual deductible</p>

* 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 Combined Evidence of Coverage and Disclosure Form for comprehensive details.

- Any amounts in excess of maximums stated in the Combined Evidence of Coverage and Disclosure Form.
- 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 Combined Evidence of Coverage and Disclosure Form.
- Services from relatives.
- Vision care except as specifically stated in the Combined Evidence of Coverage and Disclosure Form.
- Eye surgery performed solely for the purpose of correcting refractive defects.
- Hearing aids and routine hearing tests except as specifically stated in the Combined Evidence of Coverage and Disclosure Form.
- Sex changes.
- Dental and orthodontic services except as specifically stated in the Combined Evidence of Coverage and Disclosure Form.
- Cosmetic surgery.
- Routine physical examinations except as specifically stated in the Combined Evidence of Coverage and Disclosure Form.
- Treatment of mental or nervous disorders and substance abuse (including nicotine use) or psychological testing, except as specifically stated in the Combined Evidence of Coverage and Disclosure Form.
- 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 or dietary 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 Combined Evidence of Coverage and Disclosure Form.
- Care or treatment provided in a non-contracting hospital.
- Private duty nursing except as specifically stated in the Combined Evidence of Coverage and Disclosure Form.
- 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.

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

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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 Managed Health Care

The California Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at 800-627-8797 and use your health plan's grievance process before contacting the DMHC. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the DMHC for assistance. Your case may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency or urgent medical services. The DMHC also has a toll-free telephone number (888-HMO-2219), and TDD line (877-688-9891)

for the hearing- and speech-impaired. The department's Internet website, www.hmohelp.ca.gov, has complaint forms, IMR application forms and instructions online.

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.