Preferred Basic Health Benefit Plan
Summary Disclosure Form for Groups

This summary provides you with the deductible, coinsurance, copayment, and a brief description of your benefits. Eligible charge: Payment to most Non-Preferred Providers will be subject to Anthem Blue Cross and Blue Shield’s eligible charge. For more complete information, see your certificate.

<table>
<thead>
<tr>
<th></th>
<th>Preferred Providers:</th>
<th>Non-Preferred Providers:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DEDUCTIBLE</strong> (calendar year deductible for all covered services):</td>
<td>$1,500 per member</td>
<td>$3,000 per member</td>
</tr>
<tr>
<td><strong>OUT-OF-POCKET MAXIMUM</strong> The out-of-pocket maximum includes the deductible and coinsurance paid by each member during each benefit year:</td>
<td>$4,500 per member</td>
<td>$8,000 per member</td>
</tr>
<tr>
<td><strong>Stop Loss</strong></td>
<td>Benefits are paid at 70% of the first $10,000 of eligible expenses and 100% of eligible expenses thereafter.</td>
<td>Benefits are paid at 50% of the first $10,000 of eligible expenses and 100% of eligible expenses thereafter.</td>
</tr>
<tr>
<td><strong>Lifetime Maximum</strong></td>
<td>$1,000,000 per member.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Services</th>
<th>Preferred Providers</th>
<th>Non-Preferred Providers</th>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance Services</td>
<td>70% 50%</td>
<td></td>
<td>Benefits are paid for medically necessary ground or air ambulance transportation.</td>
</tr>
<tr>
<td>Alcohol and Substance Abuse</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>Benefits are not provided for this type of service.</td>
</tr>
<tr>
<td>Chemotherapy, Hemodialysis, and</td>
<td>70% 50%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiation Therapy</td>
<td>70% 50%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic Services</td>
<td>70% 50%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Care and Urgent Care</td>
<td>70% 50%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Health Care</td>
<td>70% 50%</td>
<td></td>
<td>Benefits are paid up to 30 visits per calendar year.</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>70% 50%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Care Inpatient/Outpatient</td>
<td>70% 50%</td>
<td></td>
<td>Requires prior authorization. Without prior authorization benefits will be provided at 50% for Preferred and Non-Preferred Providers.</td>
</tr>
<tr>
<td>Maternity Care1</td>
<td>Inpatient/Outpatient</td>
<td>70% 50%</td>
<td>Benefits are provided same as any other illness.</td>
</tr>
<tr>
<td>Major Organ Transplant</td>
<td>70% 50%</td>
<td></td>
<td>Benefits are paid for non-experimental human-to-human procedures, up to $100,000 per lifetime.</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>70% 50%</td>
<td></td>
<td>Benefits are not provided for this type of service.</td>
</tr>
</tbody>
</table>

1 Mandatory rider for small employer groups with 15-50 employees. Optional rider for small employer groups with 2-14 employees.

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97250 disclosure (Rev. 6-05)
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<tr>
<td>Physical Rehabilitation (physical,</td>
<td>70%</td>
<td>50%</td>
<td>Benefits are paid up to 60 days per calendar year.</td>
</tr>
<tr>
<td>occupational, and speech therapy)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Visits</td>
<td>$20 copayment</td>
<td>50%</td>
<td>Professional services for inpatient and outpatient home or office visits. The copayment</td>
</tr>
<tr>
<td>Inpatient/Outpatient</td>
<td></td>
<td></td>
<td>includes laboratory, pathology, and X-ray.</td>
</tr>
<tr>
<td>Preventive Care</td>
<td>$20 copayment</td>
<td>50%</td>
<td>Benefits are paid for:</td>
</tr>
<tr>
<td>Benefits are paid up to $250 per member</td>
<td></td>
<td></td>
<td>up to $250 per member per calendar year, not subject to deductible.</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>70%</td>
<td>50%</td>
<td>Benefits are paid for inpatient services and supplies up to 30 days per calendar year,</td>
</tr>
<tr>
<td>Spinal Manipulations</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>except private room charges that exceed the semiprivate room rate.</td>
</tr>
<tr>
<td>Supplies, Equipment, and Appliances (DME)</td>
<td>70%</td>
<td>50%</td>
<td>A PPO DME Provider is a professional provider who has contracted with Anthem to provide</td>
</tr>
<tr>
<td>Inpatient/Outpatient</td>
<td></td>
<td></td>
<td>supplies, equipment, and appliances.</td>
</tr>
<tr>
<td>Temporomandibular Joint Syndrome (TMJ)</td>
<td>70%</td>
<td>50%</td>
<td>Benefits are paid up to $1,000 per calendar year.</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>70%</td>
<td>50%</td>
<td>Subject to deductible.</td>
</tr>
</tbody>
</table>

**GENERAL LIMITATIONS AND EXCLUSIONS**

The following services are not covered:

1. Services for which coverage is not specifically provided, complications resulting from non-Covered Services, or services which are not Medically Necessary, whether or not recommended or provided by a Provider.

2. Personal comfort, hygiene, or convenience items such as a Hospital television, telephone, or private room when not Medically Necessary. Housekeeping or meal services as part of Home Health Care. Modifications to a place of residence, including equipment to accommodate physical handicaps or disabilities.

3. For a private room in excess of the average semi-private room and board rate.

4. Dental or orthodontic splints or dental prostheses, or any treatment on or to teeth, gums, or jaws and other services customarily provided by a dentist. Charges for dental services in connection with temporomandibular joint dysfunction are also not covered unless they are determined to be Medically Necessary. Such dental-related services are subject to the limitation shown in the Benefit Schedule.

5. Except for reconstructive surgery following a mastectomy, cosmetic procedures to improve appearance without restoring a physical bodily function.

6. Third-party physical exams for employment, licensing, insurance, school, camp, sports, or adoption purposes. Immunizations related to foreign travel. Expenses for medical reports, including presentation and preparation. Exams or treatment ordered by a court, or in connection with legal proceedings if not medically necessary or a covered service.

7. For fertility or infertility studies, diagnostic testing, advice, consultation, examination, medication, or for any treatment related to or connected in any way with the restoration or enhancement of fertility or conception by artificial means including Embryo transplants, in vitro fertilization, GIFT and ZIFT procedures and low tubal transfer.

8. For the treatment of sexual dysfunction or inadequacies, including, but not limited to, impotence and implantation of a penile prosthesis. Reversal of surgically performed sterilization or subsequent resterilization. Charges for genetic testing, counseling, treatment or therapy.

10. Surgical or invasive treatment (including gastric balloon) or reversal for reduction of weight regardless of associated medical or psychological conditions, unless determined to be Medically Necessary. Any weight loss programs, whether or not recommended, provided or prescribed by a physician or other medical practitioner.

11. Treatment of chronic marital or family problems; occupational, religious, or other social maladjustments; chronic behavior disorders; codependency; impulse control disorders, organic disorders, learning disabilities or mental retardation.

12. Institutional care which is determined to be for the primary purpose of controlling Member’s environment and Custodial Care, domiciliary care, convalescent care (other than Skilled Nursing Care) or rest cures.

13. Vision exams to determine refractive errors of vision and eyeglasses or contact. Coverage is provided for vision exams only when required to diagnose an Illness or Injury.

14. Hearing exams to determine the need for or the appropriate type of hearing aid or similar. Coverage is provided for hearing exams only when required to diagnose an Illness or Injury.

15. Ecological or environmental medicine. Use of chelation, orthomolecular substances; use of substances of animal, vegetable, chemical or mineral origin not specifically approved by the FDA as effective for treatment; electrodiagnosis; Hahnemannian dilution and succussion; magnetically energized geometric patterns; replacement of metal dental fillings; laetrile; gerovital.

16. Services for chronic, intractable pain by a pain control center or under a pain control program.

17. Acupuncture or hypnosis.

18. Treatment of an Illness or Injury resulting from riots, war, insurrection; rebellion; or armed invasion or aggression.

19. Treatment of an occupational injury or illness which is any Injury or Illness arising out of or in the course of employment for pay or profit.

20. Travel and accommodations, whether or not recommended or prescribed by a Provider.

21. Vitamins, herbal medicines, appetite suppressants, and other over-the-counter drugs. Drugs and medicines approved by the FDA for experimental or investigational use.

22. Any services provided before the Effective Date or after the termination of coverage.

23. Care for conditions that federal, state or local law requires to be treated in a public facility for which a charge is not normally made.

24. Any equipment of supplies that conditions the air, arch supports, support stockings, special shoe accessories or corrective shoes unless they are an integral part of a lower-body brace, heating pads, hot water bottles, wigs and their care and other primarily nonmedical equipment.

25. Special formulas, food supplements other than as specifically covered or special diets on an outpatient basis. (Except for the treatment of inherited metabolic disease.

26. Services, supplies or accommodations provided without cost to the Member or which the Member is not legally required to pay.

27. Milieu therapy, biofeedback, behavior modification, sensitivity training, hypnosis, hydrotherapy, electrohypnosis, electrosleep therapy, electronarcosis, narcosynthesis, rolfing, residential treatment, vocational rehabilitation and wilderness programs.

28. Experimental or investigational treatment or devices.

29. Sports medicine treatment plans intended to primarily improve athletic ability.

30. Radial keratotomy or any surgical procedure for the improvement of vision when vision can be made adequate through the use of glasses or contact lenses.

31. Any services given by a Provider to himself or to members of his family.

32. Ambulance services when a Member could be safely transported by other means. Air ambulance services when a Member could be safely transported by ground ambulance or other means.

33. Late discharge billing and charges resulting from a canceled appointment or procedure.

34. Care or treatment of an illness or injury caused by or arising out of participation in a riot, war, insurrection, rebellion, armed invasion or aggression; or sustained by a Member while in the act of committing a felony.

35. If you are eligible for Medicare, any services covered by Medicare under Parts A and B are excluded to the extent actually paid for by Medicare (applicable to individual coverage only).

36. Manual manipulation and subluxation of the spine is not covered under the Basic Plan.

37. Maternity care is not covered under the Individual Basic Plan. Maternity care is an optional benefit for groups of 2 to 15. Covered for groups of 15 to 50. Complications of pregnancy are covered. Maternity is covered as any other illness under the Standard Plan.

38. Alcohol and Drug Abuse Treatment Services, Mental Health Services, and Services for Treatment of Severe Mental Illness are not covered under the Basic Plan.

This summary of coverage is provided to assist you in making a decision about health care insurance. As with any health care coverage, there are limitations and exclusions. A complete list and description of benefits, limitation and exclusions are found in and are governed by the Membership Certificate.
Coverage for treatment as part of a clinical trial:
Includes coverage for medical treatment provided in a Phase II, Phase III or Phase IV clinical trial for the treatment of cancer or chronic fatigue syndrome conducted in the state of Nevada.

Coverage for medical treatment is limited to:
- Any drug or device approved for sale by the Food and Drug Administration.
- The cost of any reasonably necessary health care services required from the medical treatment or complications thereof arising out of the medical treatment provided in the clinical trial.
- The initial consultation to determine whether the person is eligible to participate in a clinical trial.
- Health care services required for the clinically appropriate monitoring of the person during the clinical trial.

Coverage for the management and treatment of diabetes
Includes coverage for medication, equipment, supplies, and appliances that are medically necessary for the treatment of diabetes type I, type II, and gestational diabetes.

Coverage for self-management of diabetes, including:
- The training and education provided to a person covered under the contract after initial diagnosis of diabetes which is medically necessary for the care and management of diabetes, including, without limitation, counseling in nutrition and the proper use of equipment and supplies for the treatment of diabetes.
- Training and education which is medically necessary as a result of a subsequent diagnosis that indicates a significant change in the symptoms or condition of the program of self-management of diabetes.
- Training and education which is medically necessary because of the development of new techniques and treatment for diabetes.

Medically Necessary
An intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury and that Anthem, subject to a member’s right to appeal, solely determines to be:
- Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the condition, illness, disease or injury.
- Obtained from a physician and/or licensed, certified or registered provider.
- Provided in accordance with applicable medical and/or professional standards.
- Known to be effective, as proven by scientific evidence, in materially improving health outcomes.
- The most appropriate supply, setting or level of service that can safely be provided to the member and which cannot be omitted consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained as an outpatient).
- Cost-effective compared to alternative interventions, including no intervention ("cost effective" does not mean lowest cost).
- Not experimental/investigational.
- Not primarily for the convenience of the member, the member’s family or the provider.
- Not otherwise subject to an exclusion under the Certificate.

The fact that a physician and/or provider may prescribe, order, recommend or approve care, treatment, services or supplies does not, of itself, make such care, treatment, services or supplies medically necessary.

Eligible Charge Reimbursement for covered services is based upon Eligible Charge as determined by Anthem. Eligible Charge means the Contracted Amount for Preferred Providers or the amount billed by a Non-Preferred Providers. Anthem’s determination of Eligible Charge is the maximum amount approved for any particular service. Deductible, coinsurance, or other cost sharing amounts are based on this allowance and are the amounts the member pays the provider.

Emergency
Emergency means a sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that a prudent person would believe that the absence of immediate medical attention could result in:
- Serious jeopardy to the health of the insured, or
- Serious jeopardy to the health of an unborn child, or
- Serious impairment to bodily functions, or
- Serious and permanent dysfunction of any bodily organ or part.

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Limitations and Exclusions
This plan does not cover some services. The plan includes limitations and exclusions to protect against duplicate or unnecessary services that could unfairly offset the cost of health care coverage for the entire plan. Please note the following examples of some of the plan's limitations and exclusions:

- Benefits provided under any local, state, or federal laws, including Workers' Compensation and Medicare
- Cosmetic surgery
- Services by a family member
- Weight-reduction services
- Complications from non-covered services
- Our payment allowance will be reduced or denied from what would have been paid if pre-certification is not obtained prior to receiving inpatient hospital services and outpatient surgeries.
- Most services, such as non-emergency hospital admissions or surgical procedures require prior authorization.
- For Individual policies, expenses resulting from pre-existing conditions are not paid until the coverage has been in effect for 12 consecutive months.
- For timely entrants of Small Group Anthem policies, expenses resulting from pre-existing conditions are not paid until the coverage has been in effect for 6 consecutive months, unless the member was covered by creditable coverage within 63 days of the replacement of the group sponsored plan. For late entrants with no prior creditable coverage, expenses resulting from pre-existing conditions are not paid until the coverage has been in effect to 18 consecutive months.

Rate determinations
1. Individual policies:
   - Rates are based on age, gender, benefit plan, family size, geographic location and tobacco use.
   - For families with more than three children, the family rate is capped at three children.
   - When a member or spouse attains an age that requires a rate change to a new category, the adjustment will be made the month following his or her birthday.
   - Rates are subject to change with 60-day written notice.
2. Small Group policies (50 or fewer employees):
   - Rates are calculated based on allowable case characteristics of member age, geographic location, dependent enrollment, group size, industry, and health status.

Individual policies – This coverage is renewable at your option, except for the following reasons:

- Non-payment of the required premium;
- Fraud or intentional misrepresentation of material fact;
- The commissioner finds that the continuation of the coverage would not be in the best interest of the policyholders, the plan is obsolete, or would impair the carrier’s ability to meet its contractual obligations;
- The carrier elects to discontinue offering and non-renew all of its individual, small group or large group plans delivered or issued for delivery in Nevada.

Small Group policies – This coverage is renewable at the option of the plan sponsor, except for the following reasons:

- Non-payment of the required premium;
- Fraud or intentional misrepresentation of material fact;
- Fails to comply with participation or contribution rules;
- The carrier decides to discontinue offering coverage under group insurance in Nevada.

Provider Directories
Copies of provider directories for all products offered by Anthem or HMO Nevada may be obtained by calling the customer service department or accessing the information on our Internet site at www.Anthem.com.

Provider Network
Under HMO Nevada, if care is not provided by the member’s Primary Care Physician or other in-network provider and care is received by a doctor who does not participate in the HMO Nevada provider network, the member may have to pay for those services.

Under Anthem PPO plans, member’s choose physicians, hospitals and other health care providers from the Anthem preferred provider organization (PPO) network. Using the PPO network can mean substantial savings. If care is received outside the PPO network, the member will pay a higher deductible and coinsurance and charges over the Allowable Charge.

Guaranteed Eligibility for Basic and Standard Plans
Basic and Standard Health Benefit Plans are available and will be issued to small groups and individuals upon application, and determination of eligibility, for such coverage.