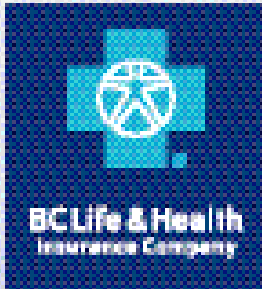


For businesses with 2-50 employees

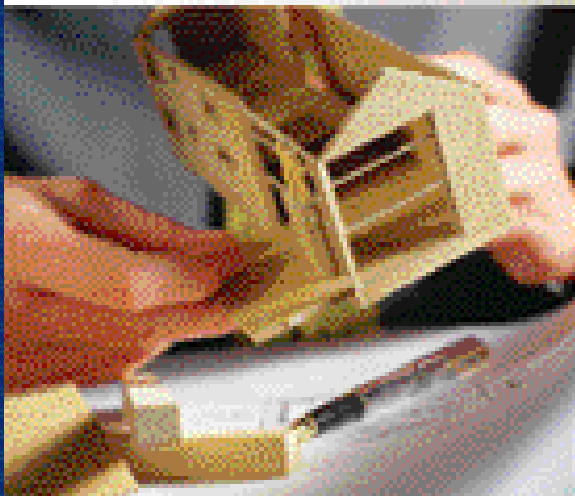


EmployeeElect Medical Plans

More choices. More control.

Solutions

Small Business Health Care Plans **at Work**



Solutions at Work from BLUE CROSS



Designed for Small Businesses

Blue Cross understands the challenges that small businesses face, and we draw upon our parent company's experience as the #1 health benefits company in the U.S. to create solutions designed especially for you.

Our EmployeeElect medical plans portfolio offers unique advantages for businesses with 2-50 employees:

- **Full choice of 12 PPOs and 4 HMOs** – you can offer just one, a mix 'n match selection, or all plans
- **Administrative ease** – integrated billing and customer service make it easy for you to offer as many different plans and types of coverage desired
- **Financial control** – three ways to approach your monthly contribution to your employees' medical premiums (employees pay the rest through payroll deduction):
 - Fixed Dollar Contribution – you pay \$100 or more
 - Traditional Contribution – you pay 50% or more
 - Percentage and Plan Contribution – you pay 50% or more, tied to a specific plan
- **Rate guarantees** – you enroll with an initial full 12-month rate and benefit guarantee
- **Workers' Compensation discount** and potential medical premium savings with Integrated MediComp
- **Additional savings opportunities** when you purchase Dental and Life along with Medical
- **Potential tax advantages** for your company

This guide is designed to help you use our EmployeeElect portfolio to build the best benefits package for your company.

Use this guide to build your Medical benefits.

Discounts & Offers for You

Blue Cross gives you the whole package, including Medical plans from Blue Cross of California (BCC) and BC Life & Health Insurance Company (BCL&H), Workers' Compensation coverage from Employers Compensation Insurance Company (ECIC), Vision coverage and Life insurance coverage from BCL&H, and Dental plans from BCC and BCL&H. And you save a substantial amount of time and money when you purchase some or all products from one reliable source, with the advantage and convenience of a consolidated bill.

Wrap up your savings:

- **Automatic 10% Workers' Compensation discount** – integrate Workers' Compensation coverage from ECIC with Medical (Integrated MediComp), and receive an automatic 10% discount off the Workers' Comp portion of your integrated bill
- **Possible Medical savings with Integrated MediComp** – in addition to the Workers' Comp discount, you may also qualify for savings on your Medical premium with Integrated MediComp
- **1% Medical savings** – when you purchase \$25,000 or more of Life along with Medical (at the same time), you'll receive 1% savings on your Medical premium ... an amount that often covers a significant portion of the Life premium cost
- **6% Life savings & 6% Dental savings** – purchase both \$25,000 or more of Group Life insurance and any of our insured Dental plans along with Medical (at the same time), and receive 6% savings on your Life premium and 6% savings on your Dental premium

See pages 15-16 for details on our Dental, Vision, and Life coverage



A Sure Thing

AB1672-qualifying small businesses are guaranteed group health coverage, and you can't be charged more than +/- 10% of the standard rate. Not to mention you'll have the satisfaction of knowing that you're doing the right thing ... for your company and your employees.

Tax Advantages, Too

Because health insurance premiums are treated as a general business expense, you can deduct premiums and health benefit costs.

For even more tax savings, ask your Blue Cross agent about a Premium Only Plan (P.O.P.) from Ceridian Benefits Services. This affordable option lets you take advantage of IRS Section 125 provisions to help cut your payroll taxes and increase your employees' take-home pay.

Consultation with a tax advisor is recommended.

Ask your Blue Cross agent for more information or turn the page to get started...

Add more value with these cost-saving solutions.

First

Use this grid to start building your company's medical benefits package. **Consider** your priorities and note which plans match those needs. **Compare** key benefits and relative prices.

Next

Go to the page numbers shown in the "What Are Your Priorities?" column for more detailed plan information. Before making your final selections, be sure to review the Exclusions and Limitations on pages 17-18 and the Summary of Features brochures for your chosen plans.

Why PPO?

Our Preferred Provider Organization (PPO) plans are served by one of the largest provider networks in California, with negotiated rates that save members 30 to 40 percent when they choose in-network providers. PPOs are favored by those who want more control over their health care decisions, access to any doctor or specialist they choose, and are willing to pay a little more for health care services received throughout the year in exchange for lower premiums every month.

Why HMO?

With a Health Maintenance Organization (HMO) plan, members choose a Primary Care Physician who oversees their health care and authorizes specialty care if needed. HMOs are preferred by members who anticipate frequent doctor visits and are willing to pay slightly higher premiums each month in exchange for lower, predictable costs when they receive health care services throughout the year.

Why Not Both—or All?

You decide how many plans to offer your employees ... just one, a mix of PPO(s) and/or HMO(s), or all plans—giving your employees maximum choice.

What Are Your Priorities?

	PLANS	Member in-network Annual Deductible
Affordable Protection Our most affordable PPOs provide solid protection at budget-friendly prices See Pages 5-6	Basic PPO *	\$1,250
	Saver PPO *	\$500 See pages 5-6 for details
	PPO \$35 Copay GenRx *	\$500
Leading Choices Our top-selling, mid-range PPO plans offer an ideal balance between cost and comprehensive benefits See Pages 7-8	PPO \$40 Copay **	\$500
	PPO \$30 Copay **	\$500
	Advantage PPO \$25 Copay *	\$250
Superior Designs Our high-end Premier PPO plans have rich benefits and the most comprehensive coverage See Pages 9-10	Premier PPO \$20 Copay **	\$250
	Premier PPO \$10 Copay **	\$250
Dollars and Sense These comprehensive PPO plans expand member control and financial opportunity <ul style="list-style-type: none"> HSA-Compatible plans combine health coverage and financial strategy options Power HealthFunds offer "first dollar coverage" before deductible is met See Pages 11-12	PPO 3500 (HSA-Compatible) *	\$3,500
	PPO 2400 (HSA-Compatible) *	\$2,400
	Power HealthFund 500 *	First, plan pays \$500; then member pays \$1,000 deductible
	Power HealthFund 750 *	First, plan pays \$750; then member pays \$500 deductible
Simple Consistency HMOs are ideal for those who want to simplify decision-making and pay predictable costs See Pages 13-14	Power Select HMO Lower Price, Newer Network **	\$500
	Saver HMO Affordable Choice **	\$1,500
	Classic HMO Cost/Benefit Balance **	None
	HMO 100% Top of the Line **	None

Important: This chart is designed to help begin the selection process; it does not provide adequate information to make a final decision. Benefits listed including per family costs, go to the pages shown in the "priorities" column. Do not submit an application until you review each plan's Summary of Features

High Level Comparison

KEY BENEFITS

costs shown here – go to pages shown in the “Priorities” column for per-family costs and more complete benefit details

Annual Out-of-Pocket Maximum (includes deductible unless noted)	Office Visits	Prescription Drugs	Inpatient Hospital Charges	RELATIVE PRICE Low → High
Deductible + \$2,000	No coverage	\$10 Generic / \$25 Brand See pages 5-6 for limits	20%	
\$2,000	Limited coverage See pages 5-6 for details	\$10 Generic / \$25 Brand See pages 5-6 for limits	20%	
\$4,000	\$35/first 12; then 45%	Generics only: \$15 [Blue Cross-negotiated savings on in-network Brand drugs]	35%	
\$4,500	\$40/first 12; then 45%	\$15 Generic / \$25 Brand after \$150 Brand deductible	40%	
\$4,000	\$30/first 12; then 45%	\$15 Generic / \$25 Brand after \$150 Brand deductible	30%	
\$3,600	\$25/first 12; then 45% up to \$900; then 10% up to \$3,600	\$15 Generic / \$25 Brand	30% up to \$900, then 10% up to \$3,600	
\$3,000	\$20/first 12; then 40%	\$15 Generic / \$25 Brand	20%	
\$2,500	\$10/first 12; then 30%	\$10 Generic / \$20 Brand	10%	
\$4,000	\$35 after deductible	\$10 Generic / \$25 Brand after Annual deductible	No charge	
\$3,600	\$35 after deductible	\$10 Generic / \$25 Brand after Annual deductible	20%	
\$5,000	\$40 after first dollar coverage and deductible	\$10 Generic / \$35 Brand after \$350 Brand deductible	40%	
\$5,000	\$35 after first dollar coverage and deductible	\$10 Generic / \$30 Brand after \$250 Brand deductible	25%	
\$2,250	\$25/Primary Care Physician; \$35/Specialist Referral	\$15 Generic / \$25 Brand after \$150 Brand deductible	10%	
\$2,250	\$20	\$10 Generic / \$25 Brand after \$150 Brand deductible	No charge	
\$1,750	\$20	\$10 Generic / \$25 Brand after \$150 Brand deductible	\$250 copay per admission	
\$1,750	\$10	\$10 Generic / \$20 Brand after \$150 Brand deductible	No charge	

Relative price illustrations are based on the average Standard Employer Risk Rates for each plan. Please request a quotation for actual rates, which will vary according to geographic area and the group's risk profile.

are per-member in-network costs, subject to deductible and copayments unless otherwise stated, for initial comparison purposes only. For more complete highlights, brochure and the Sales and Enrollment Guide. * Offered by BC Life & Health Insurance Company (BCL&H) ** Offered by Blue Cross of California (BCC)

Affordable PROTECTION

Our Most

Solid protection ... at our most affordable prices

The three plans in this category provide affordable access to health care coverage, with plenty of room to grow.

All three plans begin with:

- Lower monthly premiums
- Solid protection for in-hospital care
- Immediate prescription drug benefits
- Annual HealthyCheck screening
- Up to \$5 million in lifetime benefits

Saver PPO adds limited benefits for professional services (doctors' office visits and fees). After the maximum benefit is used, member maintains access to Blue Cross negotiated in-network rates, providing a continued savings of 40-60%.

PPO \$35 Copay GenRx is a comprehensive plan with a generic-only drug benefit that keeps it more affordable. Please note:

- Generic medications must meet the same FDA standards for quality, purity and effectiveness as brand-name drugs
- Members may still purchase brand-name drugs at Blue Cross-negotiated savings by presenting their membership cards at in-network pharmacies
- The Drug Formulary, which lists generic equivalents covered by this plan, is available at www.bluecrossca.com > Visitors > Groups of 2-50 > Pharmacy > BC Formulary, or by calling Customer Service at (800) 627-8797

Please use this chart to compare the differences between plans in this category, and refer to each plan's Summary of Features brochure before making your final selection.

Benefits listed are per-member costs, subject to deductible and copayments unless otherwise stated.

		Basic PPO ¹
Annual Deductible		\$1,250 per member 2-member max
Annual Out-of-Pocket Maximum⁴	In-Network	Annual deductible plus \$2,000 per member, 2-member max; in and out-of-network combined
	Out-of-Network	
Office Visits	In-Network	Not Covered
	Out-of-Network	Not Covered
Professional Services Including maternity, diagnostic lab and X-ray	In-Network	Limited Professional Services 20% of negotiated fee
	Out-of-Network	Limited Professional Services 50% of negotiated fee plus 100% of excess charges
Hospital Inpatient and Outpatient	Participating Hospitals	20% of negotiated fee [limited outpatient services]
Prescription Drugs⁵	In-Network	\$10 generic, \$25 brand-name; 30% of negotiated fee for self-administered injectable drugs, except insulin; maximum \$500 annual Blue Cross payment with continued access to Blue Cross negotiated pharmacy prices after maximum is reached
Preventive Care	In-Network	20% of negotiated fee after annual deductible
HealthyCheckSM Annual Health Screening	In-Network	
Annual Physical Exam		

Please Note: In-network providers accept Blue Cross negotiated fee rates as payment in full for covered services. Benefits listed are based on the providers are based on customary and reasonable charges in cases of medical emergencies; when members use an out-of-network provider, they

Affordable PPOs

STRONG Foundation

Saver PPO ¹	PPO \$35 Copay GenRx
Covered hospital benefits and initial professional services ² : \$500 per member, 2-member max; deductible applies to annual out-of-pocket max Subsequent professional services with continued access to Blue Cross in-network savings: Member pays 100% of negotiated fee up to \$5,000 per member, 2-member max ³	\$500 per member 2-member max Waived for office visit, HealthyCheck Screening, and prescription drug copays; applies to out-of-pocket max
Covered hospital benefits and initial professional services ² : \$2,000 per member, 2-member max, includes annual deductible (in-and out-of-network combined) Subsequent professional services with continued access to Blue Cross in-network savings: \$5,000 per member ³	\$4,000 per member, 2-member max includes annual deductible Blue Cross payments of \$10,000 per member's covered expenses
Initial 2 visits per adult / 4 visits per child (in and out-of-network combined): \$20 copay, deductible waived Additional visits; member pays 100% of negotiated fee with continued access to Blue Cross savings ³	First 12 office visits per member: \$35 copay Additional visits: 45% of negotiated fee not subject deductible
Initial 2 visits per adult / 4 visits per child (in 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	50% of negotiated fee plus 100% of excess charges
Covered services including maternity: 20% of negotiated fee Diagnostic lab & X-ray: 20% of negotiated fee (up to a maximum \$500 Blue Cross payment in- and out-of-network combined); then member pays 100% of negotiated fee with continued access to Blue Cross savings ³	35% of negotiated fee
Covered services including maternity: 50% of negotiated fee plus 100% of excess charges Diagnostic lab & X-ray: 50% of negotiated fee plus 100% of excess charges (up to a maximum \$500 Blue Cross payment in- and out-of-network combined); then member pays 100% of negotiated fee plus all excess charges ³	50% of negotiated fee plus 100% of excess charges
20% of negotiated fee (limited outpatient services)	35% of negotiated fee
\$10 generic, \$25 brand-name; 30% of negotiated fee for self-administered injectable drugs, except insulin; maximum \$500 annual Blue Cross payment with continued access to Blue Cross negotiated pharmacy prices after maximum is reached	\$15 generic; 30% of negotiated fee for generic self-administered injectable drugs, except insulin (plan covers generic drugs only; see page 5 for information on how to obtain the Formulary and purchase brand-name drugs at Blue Cross negotiated savings)
20% of negotiated fee, not subject to annual deductible	\$35 office visit copay (not subject to deductible) plus 35% of negotiated fee for all other covered services (after annual deductible)
\$25 or \$75 copay health screening options, not subject to annual deductible	
Not Covered	

All three plans in this category are offered by BC Life & Health Insurance Company.

¹ Saver PPO and Basic PPO are basic hospital and limited professional benefits plans. Some covered services are limited.

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-ray 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-ray 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 Expenses that contribute to the annual out-of-pocket maximum vary from plan to plan and have restrictions and limitations. Refer to each plan's Certificate for full details.

⁵ 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 the generic copay plus the difference in cost between the brand-name drug and the generic equivalent drug.



negotiated fee rate for in-network providers (out-of-network providers can charge more than the negotiated fee rate); benefits listed for out-of-network must pay the applicable copayment or coinsurance, plus any charges that exceed that allowable amount.

Leading CHOICES

Top-Selling PPOs

Mid-range balance makes these PPOs our top-selling plans

For those seeking an ideal balance between affordable cost and comprehensive coverage, these PPO plans offer:

- Moderate annual deductibles that apply toward the member's out-of-pocket maximum
- Immediate benefits with modest copays for prescription drugs and office visits
- Annual Medical Deductible is waived for prescription drug and office visit copays and HealthyCheckSM
- Optional HealthyCheck preventive care screenings
- \$5 million in lifetime benefits

The most comprehensive plan in this category, Advantage PPO \$25 Copay has the lowest annual deductible, annual physical exam benefits, and no brand-name prescription drug deductible.

Please use this chart to compare the differences between plans in this category, and refer to each plan's Summary of Features brochure before making your final selection.

Benefits listed are per-member costs, subject to deductible and copayments unless otherwise stated.

		PPO \$40 Copay
Annual Deductible Waived for office visits, prescription drugs and HealthyCheck benefits; applies to Annual Out-of-Pocket Maximum		\$500 per member 2-member max
Annual Out-of-Pocket Maximum¹ Includes annual deductible	In-Network	\$4,500 per member, 2-member max
	Out-of-Network	Blue Cross payments of \$10,000 per member's covered expenses
Office Visits Not subject to annual deductible	In-Network	First 12 visits per member: \$40 copay Additional visits: 45% of negotiated fee
	Out-of-Network	50% of negotiated fee, plus 100% of excess charges
Professional Services Including maternity, diagnostic lab and X-ray After annual deductible	In-Network	40% of negotiated fee
	Out-of-Network	50% of negotiated fee, plus 100% of excess charges
Hospital Inpatient and Outpatient	Participating Hospitals	40% of negotiated fee after annual deductible
Prescription Drugs² Not subject to annual medical deductible; amounts shown are copays for each 30 day supply; up to 60 day supply available through mail order	In-Network	\$15 generic, \$25 brand-name after annual \$150 brand-name prescription drug deductible per member; 30% of negotiated fee for self-administered injectable drugs, except insulin (subject to brand-name prescription drug deductible if applicable)
Preventive Care Well Baby Immunizations; Ages 7-Adult screening tests include annual Pap, breast exam & mammogram for women & Prostate Specific Antigen for men	In-Network	\$40 office visit copay (not subject to deductible) plus 40% of negotiated fee for all other covered services (after annual deductible)
HealthyCheckSM Annual Health Screening Not subject to annual deductible	In-Network	\$25 or \$75 copay health screening options
Annual Physical Exam Ages 7-Adult	In-Network	Not covered

¹ Annual Out-of-Pocket Maximum: Expenses that contribute to the maximum copayment limit vary from plan to plan and have restrictions and

² Prescription Drugs: If a member selects a brand-name drug when a generic equivalent drug is available, even if the physician writes a "dispense drug and the generic equivalent drug. The amount paid does not apply to the member's brand-name prescription drug deductible (PPO \$40 and

³ Annual Physical Exam: Maximum annual benefit \$200 for members covered more than six months; \$100 for members covered six months or less.

Please Note: In-network providers accept Blue Cross negotiated fee rates as payment in full for covered services. Benefits listed are based on the providers are based on customary and reasonable charges in cases of medical emergencies; when members use an out-of-network provider, they

PPO \$30 Copay	Advantage PPO \$25 Copay
\$500 per member 2-member max	\$250 per member 2-member max
\$4,000 per member, 2-member max	\$3,600 per member, 2-member max
Blue Cross payments of \$10,000 per member's covered expenses	Blue Cross payments of \$10,000 per member's covered expenses
First 12 visits per member: \$30 copay Additional visits: 45% of negotiated fee	First 12 visits per member: \$25 copay; Additional visits: 45% of negotiated fee up to \$900 and then 10% from \$901 to \$3,600
50% of negotiated fee, plus 100% of excess charges	50% of negotiated fee, plus 100% of excess charges
30% of negotiated fee	30% of negotiated fee up to \$900 and then 10% from \$901 to \$3,600
50% of negotiated fee, plus 100% of excess charges	50% of negotiated fee, plus 100% of excess charges
30% of negotiated fee after annual deductible	30% of negotiated fee up to \$900 and then 10% from \$901 to \$3,600 after annual deductible
\$15 generic, \$25 brand-name after annual \$150 brand-name prescription drug deductible per member; 30% of negotiated fee for self-administered injectable drugs, except insulin (subject to brand-name prescription drug deductible if applicable)	\$15 generic, \$25 brand-name; 30% of negotiated fee for self-administered injectable drugs, except insulin
\$30 office visit copay (not subject to deductible) plus 30% of negotiated fee for all other covered services (after annual deductible)	\$25 office visit copay (not subject to deductible) plus 30% of negotiated fee for all other covered services up to \$900 and then 10% from \$901 to \$3,600 (after annual deductible)
\$25 or \$75 copay health screening options	Each year, members Ages 7-Adult may choose between a HealthyCheck screening or a physical exam; deductible waived. \$25 or \$75 copay health screening options
Not covered	OR \$25 office visit copay plus 30% of negotiated fee for all other covered services up to \$900 and then 10% from \$901 to \$3,600 ³

The PPO \$40 Copay and PPO \$30 Copay plans are offered by Blue Cross of California. The Advantage PPO \$25 Copay Plan is offered by BC Life & Health Insurance Company.

limitations. Refer to each plan's Combined Evidence of Coverage and Disclosure Form or Certificate for full details.

as written" or "do not substitute" prescription, the member will be responsible for the generic copay plus the difference in cost between the brand-name \$30 Copay Plans Only).

negotiated fee rate for in-network providers (out-of-network providers can charge more than the negotiated fee rate); benefits listed for out-of-network must pay the applicable copayment or coinsurance, plus any charges that exceed that allowable amount.

Crafted for those who demand the most comprehensive coverage available

Our two Premier Plans offer top-of-the-line coverage to satisfy the most demanding needs.

These plans feature:

- Low annual deductibles that apply toward the member's out-of-pocket maximum
- Annual deductible is waived for prescription drug and office visit copays, HealthyCheckSM and certain annual physical exam benefits
- Immediate benefits with modest copays for prescription drugs and office visits
- Our most comprehensive coverage for out-of-network services
- Our most liberal brand-name prescription drug benefits, including no brand-name drug deductible
- Choose either an annual physical exam or a yearly HealthyCheck screening; deductible waived
- \$5 million in lifetime benefits

With rich benefits and liberal coverage, these plans earn the name "premier."

Please use this chart to compare the differences between plans in this category, and refer to each plan's Summary of Features brochure before making your final selection.

Benefits listed are per-member costs, subject to deductible and copayments unless otherwise stated.

		Premier PPO \$20 Copay
Annual Deductible Waived for office visits, prescription drugs and HealthyCheck benefits; applies to Annual Out-of-Pocket Maximum		\$250 per member 2-member max
Annual Out-of-Pocket Maximum¹ Includes annual deductible	In-Network	\$3,000 per member, 2-member max
	Out-of-Network	\$5,000 per member, 2-member max
Office Visits Not subject to annual deductible	In-Network	First 12 visits per member: \$20 copay Additional visits: 40% of negotiated fee
	Out-of-Network	40% of customary & reasonable charges, plus 100% of excess charges
Professional Services Including maternity, diagnostic lab and X-ray After annual deductible	In-Network	20% of negotiated fee
	Out-of-Network	40% of customary & reasonable charges, plus 100% of excess charges
Hospital Inpatient and Outpatient After annual deductible	Participating Hospitals	20% of negotiated fee
Prescription Drugs² Not subject to annual deductible; amounts shown are copays for each 30 day supply; up to 60 day supply available through mail order	In-Network	\$15 generic, \$25 brand-name; 30% of negotiated fee for self-administered injectable drugs, except insulin
Preventive Care Well Baby Immunizations; Ages 7-Adult screening tests include annual Pap, breast exam & mammogram for women & Prostate Specific Antigen for men	In-Network	\$20 office visit copay (not subject to deductible) plus 20% of negotiated fee for all other covered services (after annual deductible)
Annual Options - Each year, members Ages 7-Adult may choose between a HealthyCheck screening or a physical exam; deductible waived		
HealthyCheckSM Screening	In-Network	\$25 or \$75 copay health screening options
OR		
Physical Exam³	In-Network	\$20 office visit copay plus 20% of negotiated fee for all other covered services

¹ Annual Out-of-Pocket Maximum: Expenses that contribute to the maximum copayment limit vary from plan to plan and have restrictions and limitations.

² Prescription Drugs: Members may select a brand-name drug when a generic equivalent drug is available if the physician writes a "dispense as written"

³ Annual Physical Exam: Maximum annual benefit \$200 for members covered more than six months; \$100 for members covered six months or less.

Please Note: In-network providers accept Blue Cross negotiated fee rates as payment in full for covered services. Benefits listed are based on the providers are based on customary and reasonable charges; when members use an out-of-network provider, they must pay the applicable copayment

Premier PPO \$10 Copay	
	\$250 per member 2-member max
	\$2,500 per member, 2-member max
	\$5,000 per member, 2-member max
	First 12 visits per member: \$10 copay Additional visits: 30% of negotiated fee
	30% of customary & reasonable charges, plus 100% of excess charges
	10% of negotiated fee
	30% of customary & reasonable charges, plus 100% of excess charges
	10% of negotiated fee
	\$10 generic, \$20 brand-name; 30% of negotiated fee for self-administered injectable drugs, except insulin
	\$10 office visit copay (not subject to deductible) plus 10% of negotiated fee for all other covered services (after annual deductible)
	\$25 or \$75 copay health screening options
	\$10 office visit copay plus 10% of negotiated fee for all other services

Premier PPO \$20 Copay and Premier PPO \$10 Copay plans are offered by Blue Cross of California.



Refer to each plan's Combined Evidence of Coverage and Disclosure Form or Certificate for full details.
or "do not substitute" prescription.

negotiated fee rate for in-network providers (out-of-network providers can charge more than the negotiated fee rate); benefits listed for out-of-network or coinsurance, plus any charges that exceed that allowable amount.

Budget-wise solutions put members in control

These four PPO plans offer innovative, affordable alternatives for those seeking more control of health care and financial decisions.

PPO 3500 (HSA-Compatible) and PPO 2400 (HSA-Compatible) Plans

High deductible health plans work hand in hand with Health Savings Accounts (HSAs) to provide affordable health coverage and potential tax advantages ... for both employees and employers.

- Employers who choose to contribute to employees' HSA may be eligible for additional tax advantages*
- Employees can use tax-deductible contributions to their HSAs (and tax-free interest) to pay for qualified medical expenses not covered by the health plan

Through our arrangement with JPMorgan Bank, N.A. (Chase), employees have the option of applying for a Chase HSA at the same time they enroll in the Blue Cross health plan.

Power HealthFund 500 and Power HealthFund 750 Plans

Each year members are allowed a set amount of first dollar coverage for eligible expenses before they satisfy their medical deductible, and unused amounts roll over for a year. With careful budgeting and in-network provider savings, the first dollar coverage can be sufficient for an average member's yearly medical expenses.

Please use this chart to compare the differences between plans in this category, and refer to each plan's Summary of Features brochure before making your final selection.

Per-member costs shown here unless otherwise stated.

		PPO 3500 (HSA-Compatible)
First Dollar Coverage Applies to Power HealthFund Plans only; In-Network and Out-of-Network combined; amounts paid do not apply toward annual deductible or maximum copayment limits		Not Applicable
Annual Medical Deductible Applies to Annual Out-of-Pocket Maximum		First, member pays 100% of expenses up to expenses combined; in and out-of-network \$3,500 per member \$7,000 family aggregate
Annual Out-of-Pocket Maximum Includes annual deductible; per-family amount is aggregate, i.e., once one or more family members' eligible covered expenses (combined) meet this amount, the requirement is satisfied for all covered family members	In-Network	Medical/pharmacy combined; in and out-of-network \$4,000 per member \$7,500 family aggregate
	Out-of-Network	Member responsible for all charges over allowable
Office Visits	In-Network	\$35 copay after annual deductible
	Out-of-Network	50% of negotiated fee plus 100% of excess charges after annual deductible
Professional Services (including maternity, diagnostic lab and X-ray)	In-Network	Plan pays 100% of negotiated fee after annual deductible
	Out-of-Network	50% of negotiated fee plus 100% of excess charges after annual deductible
Hospital Inpatient and Outpatient	Participating Hospitals	Plan pays 100% of negotiated fee after annual deductible
Prescription Drugs Amounts shown are copays for 30 day supplies purchased at In-Network Pharmacies; up to a 60 day supply available through mail order		\$10 generic; \$25 brand-name; 30% of negotiated fee for self-administered injectable drugs, except insulin after combined medical/pharmacy deductible is met
Preventive Care: In-Network Well Baby Immunizations; Ages 7-Adult screening tests include annual Pap, breast exam & mammogram for women & Prostate Specific Antigen for men		\$35 office visit copay (not subject to deductible) plan pays 100% of negotiated fee for all other covered services after annual deductible
HealthyCheckSM Annual Health Screening	In-Network	Each year, members Ages 7-Adult may choose between deductible waived. \$25 or \$75 copay health screening options
Annual Physical Exam	In-Network	OR \$35 office visit copay plus any negotiated fee amount in excess of the Blue Cross payment

Please Note: In-network providers accept Blue Cross negotiated fee rates as payment in full for covered services. Benefits listed are based on the providers are based on customary and reasonable charges in cases of medical emergencies; when members use an out-of-network provider, they

vvy PPOs

Put Your MONEY TO WORK

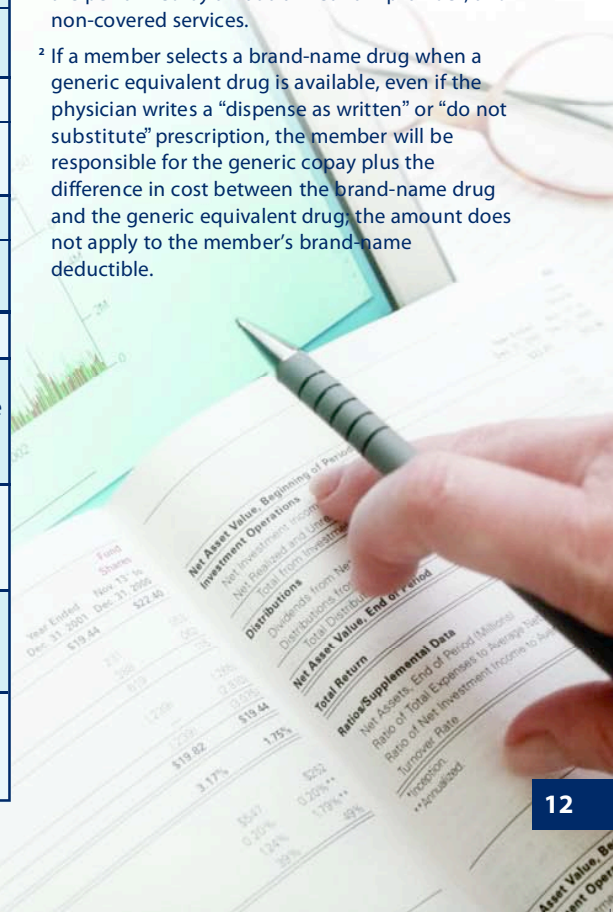
PPO 2400 (HSA-Compatible)	Power HealthFund 500	Power HealthFund 750
Not Applicable	First, the plan pays 100% of member's covered expenses up to these amounts for all covered services EXCEPT prescription drugs:	
	\$500 per member; \$1,000 family aggregate	\$750 per member; \$1,500 family aggregate
these amounts for covered medical/pharmacy combined (before plan benefits begin):	Next, member pays 100% of expenses up to these amounts for covered services (before copay & coinsurance begin):	
\$2,400 per member \$4,800 family aggregate	\$1,000 per member \$2,000 family aggregate	\$500 per member \$1,000 family aggregate
combined; certain payments do not apply ¹		
\$3,600 per member \$5,500 family aggregate	\$5,000 per member \$10,000 family aggregate	\$5,000 per member \$10,000 family aggregate
amount when using a non-participating provider	Plan pays maximum of \$10,000 per member; \$20,000 family aggregate	Plan pays maximum of \$10,000 per member; \$20,000 family aggregate
\$35 copay after annual deductible	\$40 copay	\$35 copay
50% of negotiated fee plus 100% of excess charges after annual deductible	50% of negotiated fee plus 100% of excess charges	50% of negotiated fee plus 100% of excess charges
20% of negotiated fee after annual deductible	40% of negotiated fee	25% of negotiated fee
50% of negotiated fee plus 100% of excess charges after annual deductible	50% of negotiated fee plus 100% of excess charges	50% of negotiated fee plus 100% of excess charges
20% of negotiated fee after annual deductible	40% of negotiated fee	25% of negotiated fee
\$10 generic; \$25 brand-name; 30% of negotiated fee for self-administered injectable drugs, except insulin after combined medical/pharmacy deductible	\$10 generic; \$35 brand-name ² (after annual \$350 brand-name prescription drug deductible per member); 30% of negotiated fee for self-administered injectable drugs, except insulin	\$10 generic; \$30 brand-name ² (after annual \$250 brand-name prescription drug deductible per member); 30% of negotiated fee for self-administered injectable drugs, except insulin
\$35 office visit copay (not subject to deductible) plus 20% of negotiated fee for all other covered services after annual deductible	\$40 office visit copay plus 40% of negotiated fee for all other covered services	\$35 office visit copay plus 25% of negotiated fee for all other covered services
HealthyCheck screening or a physical exam;	\$25 or \$75 copay health screening options, not subject to annual deductible	
OR \$25 or \$75 copay health screening options		
\$35 office visit copay plus 20% of negotiated fee for related covered services and any negotiated fee amount in excess of the Blue Cross payment	Not covered	

All plans listed on this page are offered by BC Life & Health Insurance Company.

***Note:** A high-deductible health plan is not a Health Savings Account (HSA). An HSA, which must be established for tax-advantaged treatment, is a separate arrangement between the individual and a bank or other qualified institution. Consultation with a tax advisor is recommended.

¹ Services that do not apply to the annual out-of-pocket maximum include, but are not limited to, copay paid for acupuncture/acupressure when performed by an out-of-network provider; copay paid for mental or nervous disorders and substance abuse (except for 7 treatment of severe mental illness and serious emotional disturbances of a child) when performed by an out-of-network provider; \$500 copay for infertility services out-of-network; copay for not obtaining preservice review when services are performed by an out-of-network provider; and non-covered services.

² 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 the generic copay plus the difference in cost between the brand-name drug and the generic equivalent drug; the amount does not apply to the member's brand-name deductible.



negotiated fee rate for in-network providers (out-of-network providers can charge more than the negotiated fee rate); benefits listed for out-of-network must pay the applicable copayment or coinsurance, plus any charges that exceed that allowable amount.

Four HMOs offer plenty of choices and price points

HMO plans are especially preferred by families with children and those who anticipate frequent doctor visits. Members choose a Primary Care Physician and enjoy predictable out-of-pocket costs. Each of our HMO plans is designed to satisfy specific needs:

- **Power Select HMO**, our most affordable HMO plan, is served by the Select Network available in 22 California counties.
- **Saver HMO** and the Power Select HMO both offer immediate benefits for office visits and the deductibles apply toward the out-of-pocket maximums.
- **Classic HMO**, with mid-range affordability, has no annual deductible and a modest, predictable copay for inpatient hospital care.
- **HMO 100%**, our richest HMO plan, has no deductible and no-charge simplicity for in-network hospital care.

Please note that the Power Select HMO plan cannot be offered along with any of our other HMO products.

Please use this chart to compare the differences between plans in this category, and refer to each plan's Summary of Features brochure before making your final selection.

Benefits listed are per-member costs, subject to deductible and copayments unless otherwise stated.

		Power Select HMO
Annual Deductible Applies to annual out-of-pocket maximum		\$500 per member Applies to inpatient & outpatient facility services, ambulatory surgical centers and dialysis centers except medical emergencies.
Annual Out-of-Pocket Maximum¹ Per family amount is aggregate, i.e., once one or more family members' eligible covered expenses (combined) meet this amount, the requirement is satisfied for all covered family members		\$2,250 per member \$4,500 family aggregate
Office Visits Includes office visits for maternity	In-Network	\$25 copay - Primary Care Physician visits \$35 copay - Specialist Referral visits Not subject to annual deductible
	Out-of-Network	Not Covered
Professional Services Including maternity, diagnostic lab and X-ray	In-Network	No Charge
	Out-of-Network	Not Covered
Hospital Inpatient and Outpatient	Participating Hospitals	Inpatient: 10% copay Outpatient: 20% copay After annual deductible
Prescription Drugs² Not subject to annual medical deductible; amounts shown are copayments for each 30 day supply; up to 60 day supply available through mail order	In-Network	\$15 generic \$25 brand-name after annual \$150 brand-name prescription drug deductible per member 30% of negotiated fee for self-administered injectable drugs, except insulin (subject to brand-name prescription drug deductible if applicable)
Lifetime In-Network Covered Charges Paid by Blue Cross		Unlimited
Network Service		Served by the Select Network available in 22 counties

¹ Annual Out-of-Pocket Maximum: Expenses that contribute to the maximum copayment limit vary from plan to plan and have restrictions and

² Prescription Drugs: If a member selects a brand-name drug when a generic equivalent drug is available, even if the physician writes a "dispense drug and the generic equivalent drug. The amount paid does not apply to the member's brand-name prescription drug deductible.

Saver HMO	Classic HMO	HMO 100%
\$1,500 per member Applies to inpatient & outpatient facility services, ambulatory surgical centers and dialysis centers except medical emergencies.	None	None
\$2,250 per member \$4,500 family aggregate	\$1,750 per member \$3,500 family aggregate	\$1,750 per member \$3,500 family aggregate
\$20 copay Not subject to annual deductible	\$20 copay	\$10 copay
Not Covered	Not Covered	Not Covered
No Charge	No Charge	No Charge
Not Covered	Not Covered	Not Covered
No charge after annual deductible	Inpatient: \$250 copay per admission Outpatient: 20% of negotiated fee	No Charge
\$10 generic \$25 brand-name after annual \$150 brand-name prescription drug deductible per member 30% of negotiated fee for self-administered injectable drugs, except insulin (subject to brand-name prescription drug deductible if applicable)	\$10 generic \$25 brand-name after annual \$150 brand-name prescription drug deductible per member 30% of negotiated fee for self-administered injectable drugs, except insulin (subject to brand-name prescription drug deductible if applicable)	\$10 generic \$20 brand-name after annual \$150 brand-name prescription drug deductible per member 30% of negotiated fee for self-administered injectable drugs, except insulin (subject to brand-name prescription drug deductible if applicable)
Unlimited	Unlimited	Unlimited
Served by the CaliforniaCare Network, available in most California counties. Employers that offer HMO coverage must choose plans from either the CaliforniaCare Network, or the Power Select HMO Plan; plans from both networks may not be offered together in a company's benefit package.		

All HMO plans are offered by Blue Cross of California.



limitations. Refer to each plan's Combined Evidence of Coverage and Disclosure Form for full details.

as written" or "do not substitute" prescription, the member will be responsible for the generic copay plus the difference in cost between the brand-name

GET THE WHOLE PICTURE **From One Source**

The Value of Dental, Vision and Life in Your Comprehensive Benefits Package

With Blue Cross, you can get all of your health benefit products **from one source**—the most trusted source in the industry. When you include Dental, Vision and Life insurance with your Medical coverage to create the **ultimate health benefit package**, you'll also have the opportunity to get the biggest savings possible and simplify benefits administration at the same time.

Brighten Your Benefits Package with Dental Coverage

from Blue Cross of California and BC Life & Health Insurance Company

Did you know that employed adults lose more than 164 million hours of work each year due to Dental disease or Dental visits?

Preventive Dental care benefits, including regular Dental checkups, can help make a difference in your employees' productivity and the number of work days lost due to Dental and health problems—saving your company time and money.

We offer **PPO, HMO and Voluntary Dental plans** – all designed to allow small businesses like yours the opportunity to provide the whole benefit package. Simply decide how much you want to contribute toward Dental premiums; your employees will pay the rest through payroll deductions.

As the 3rd largest dental carrier in California, we offer access to nearly **15,000 providers**. That means your employees can see the practitioners they prefer. Plus, your employees will enjoy **lower out-of-pocket expenses**, as we have contracted with our network dentists to provide quality care at affordable costs.

And our Dental benefits are **easy to access**, too: Employees simply choose a provider in the network, make an appointment, present their ID card, and pay any copayment or deductible for certain Dental services. The provider verifies eligibility and takes care of any claims submissions and other necessary paperwork.

Get More—and Give More—with Life Insurance

from BC Life & Health Insurance Company

Your employees depend on you, and their families depend on them. Group Term Life insurance is an easy, inexpensive way to help your employees improve their families' financial security.

Basic Group Term Life from BC Life & Health automatically includes **Accelerated Death** benefits and **Accidental Death & Dismemberment (AD&D)** coverage. AD&D coverage also includes:

- An annual \$3,000 college education benefit for eligible dependents
- A seat belt provision that adds 10% of the coverage amount (up to \$25,000) to the AD&D benefit
- A \$5,000 maximum repatriation benefit to transport mortal remains should death occur more than 75 miles from home

Did you know that only half of the U.S. workforce has access to Life insurance?

The Clear Advantage of Vision Coverage

from BC Life & Health Insurance Company

Comprehensive, inexpensive Vision plans can play a key role in managing the overall health and well-being of your employees. Regular eye exams and wearing corrective eyewear can greatly decrease the risk of more serious, long-term eye diseases—and can even result in early detection of other health conditions—increasing your employees' productivity and performance.

When you offer your employees Blue View VisionSM as part of a complete benefits package, you're giving them one of the strongest Vision coverage choices in sight. Blue View Vision's affordable plans feature comprehensive eye exams, fast delivery of eyewear, and an attractive frame allowance.

Employees also enjoy **additional savings of up to 40%** on unlimited purchases of non-covered materials, such as extra pairs of eyewear—even after they've exhausted their covered benefits.

Our broad provider network, with more than 40,000 points of access nationwide, includes independent practitioners as well as **LensCrafters[®]**, **Target Optical** and most **Sears Optical** and **Pearle Vision** retail locations. Many locations are conveniently open in the evenings and on weekends.

Blue View Vision benefits are easy to access: Employees simply choose a provider in the network, make an appointment, present their ID card, and pay any applicable copayments and any balance for non-covered services. The provider verifies eligibility and takes care of the paperwork.

Did you know that more than 65% of today's workforce wears eyeglasses or contact lenses?

The More You Buy, The More You Save

If you enroll 11 or more employees in Group Term Life, you'll automatically get the **advantages of a single rate** per \$1,000 of Life.

When you purchase \$25,000 or more of Life along with Medical (at the same time), you'll receive **1% savings** on your Medical premium. Purchase both \$25,000 or more of Life coverage and any of our insured Dental plans (at the same time), and get **6% savings** on your Life premium and **6% savings** on your Dental premium.

All This and Easy Administration, Too

When you offer the whole health benefit package from one trusted, reliable source, administration is easy. You'll receive **one consolidated bill** (that means just one premium check) and you'll have **one point of contact** (that means our dedicated Customer Service department can help with questions about any of our Specialty Products).

The Whole Picture Gives You the Ultimate Benefit Package

Now that you have the whole picture, **you can see how you and your employees can save and benefit** from offering our Dental, Vision and Life insurance with your Medical package. **Call your Blue Cross agent today and take advantage of the ultimate benefit package.**

Medical Plans Exclusions & Limitations

Exclusions and Limitations Common to All Medical Plans

- Any amounts in excess of maximums stated in the Combined Evidence of Coverage and Disclosure Form/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 Combined Evidence of Coverage and Disclosure Form/Certificate.
- Services from relatives.
- Vision care except as specifically stated in the Combined Evidence of Coverage and Disclosure Form/Certificate.
- 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/Certificate.
- Sex changes.
- Dental and orthodontic services except as specifically stated in the Combined Evidence of Coverage and Disclosure Form/Certificate.
- Cosmetic surgery.
- Routine physical examinations except as specifically stated in the Combined Evidence of Coverage and Disclosure Form/Certificate.
- 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/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 (PPO plans only).

- 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, stolen or damaged.
- 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 (PPO plans only).
- Educational Services except as specifically provided or arranged by Blue Cross.
- Infertility services (including sterilization reversal) except as specifically stated in The Combined Evidence of Coverage and Disclosure Form/Certificate.
- Care or treatment provided in a non-contracting hospital except as specifically stated in the Combined Evidence of Coverage and Disclosure Form/Certificate.
- Private duty nursing except as specifically stated in the Combined Evidence of Coverage and Disclosure Form/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 except as specifically stated in the Combined Evidence of Coverage and Disclosure Form/Certificate.

Additional Exclusions and Limitations Applicable Only to HMO Plans

- Care not authorized by your PMG or IPA.
- Amounts in excess of customary and reasonable charges for care rendered by a non-participating provider without an authorized referral from your PMG or IPA.
- Rehabilitative care, such as physical therapy, occupational therapy and speech therapy, except as specifically stated in the Combined Evidence of Coverage and Disclosure Form.

- Treatment of the jaw or teeth secondary to malocclusion or orthognathic conditions.
- Growth hormone treatment.
- Acupuncture/acupressure.
- Durable Medical Equipment except as specifically stated in the Combined Evidence of Coverage and Disclosure Form.
- Contraceptive devices unless your physician determines that oral contraceptive drugs are not medically appropriate.

Additional Exclusions and Limitations Applicable Only to Basic PPO and Saver PPO Plans

- 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.
- 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 Web site at www.bluecrossca.com or obtained by calling Small Group Customer Service at (800) 627-8797.

Utilization Review

The Blue Cross Utilization Review Program helps members receive coverage for appropriate treatment in the appropriate setting. Four review processes are included: 1) Preservice 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 Preservice 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 Blue Cross' grievance procedure. You can report your grievance by phone or in writing; see your Blue Cross ID card for the appropriate contact information. All grievances received by Blue Cross that cannot be resolved by phone (when appropriate) to the mutual satisfaction of the member and Blue Cross will be acknowledged in writing, together with a description of how 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 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 Blue Cross response letter.

For the purposes of ERISA, there is one level of appeal. For urgent care requests for benefits, 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, Blue Cross will respond within 60 calendar days from the date the appeal is received.

If the member disagrees with 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 Web site, www.hmohelp.ca.gov, has complaint forms, IMR application forms and instructions online.

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 Blue Cross first to resolve the issue. If contacts between you (the Complainant) and (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 a request or claim for medical services 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 a request or claim for medical services, or if the group is not subject to ERISA, the following provisions apply: Any dispute between the employer and/or the member and Blue Cross must be resolved by binding arbitration (not by lawsuit or trial by jury or other court process, except as California 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 Blue Cross are giving up the right to participate in class arbitration or have any dispute decided in a court of law before a jury.

Medicare

Under TEFRA/DEFRA, Medicare is the primary coverage for groups of less than 20 employees. Blue Cross coverage is considered primary coverage for groups of 20 or more employees. This 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, 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, B, C or D 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 Blue Cross of California 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. 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 Blue Cross of California and its affiliated companies' incurred medical care ratio for 2005 was 80.87 percent. This ratio was calculated after provider discounts were applied.

This brochure provides abbreviated information about benefits and exclusions and limitations. Please refer to the Certificates and/or Combined Evidence of Coverage and Disclosure Forms for comprehensive descriptions of coverage, benefits, special circumstances and limitations.



Blue Cross of California
Commercial HMO/POS Combined



The Power of BlueSM

Blue Cross of California (BCC) is a health care service plan regulated by the Department of Managed Health Care (DMHC). BC Life & Health Insurance Company (BCL&H) is an insurance company regulated by the California Department of Insurance (CDI).

BCC and BCL&H are Independent Licensees of the Blue Cross Association (BCA). The Power of Blue is a service mark and the Blue Cross name and symbol are registered service marks of the BCA.

All Small Group HMO Medical & Dental plans, Premier \$10/\$20 Copay plans and PPO \$30/\$40 Copay plans are offered by BCC. All other Small Group Medical, Dental, Vision, Group Term Life and AD&D products are offered by BCL&H.

Workers' Compensation coverage is provided through Employers Compensation Insurance Company.

Administrative services for the Premium Only Plan (P.O.P.) are provided by Ceridian Benefit Services, Inc., an independent company that is not affiliated with BCC, its affiliates or parent organization.

THIS BROCHURE IS AN OVERVIEW OF COVERAGE. A COMPREHENSIVE DESCRIPTION OF COVERAGE, BENEFITS, EXCLUSIONS AND LIMITATIONS IS CONTAINED IN THE CERTIFICATES AND/OR COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORMS.

www.bluecrossca.com