

For businesses with up to 50 EMPLOYEES



BlueCross
of California

EmployeeChoice

More Flexibility. More Access.

Solutions

Small Business Health Care Plans **at Work**



Solutions at Work from BLUE CROSS



EmployeeChoice: A Flexible Solution for Your Company

Blue Cross understands the unique needs of small businesses, and we're always striving to create solutions that work ... for you and your employees.

EmployeeChoice is a unique program designed for employers who want Blue Cross health coverage, but are also sensitive to their employees who prefer a non-Blue Cross HMO. With EmployeeChoice, you can have the best of Blue Cross side-by-side with another carrier's HMO.

The package includes five of our popular plans (four PPOs and one HMO) as well as all the savings and advantages you expect from Blue Cross of California and BC Life & Health Insurance Company. Plus, you get the convenient option of one-stop shopping for Medical, Workers' Compensation, Life, Dental and Vision coverage, with savings and discounts when you purchase these products together.

Ask your **Blue Cross** agent how **EmployeeChoice** can

Solutions at Work

EmployeeChoice features:

Choice of four PPOs and one HMO – you can offer just one, a mix 'n match selection, or all plans – and you get the unique ability to offer another carrier's HMO

Financial control – three ways to fix your monthly contribution to your employees' medical premiums (they pay the rest through payroll deduction):

- Fixed Dollar Contribution – you pay \$100 or more (in \$5 increments)
- Traditional Contribution – you pay 50% or more
- Percentage and Plan Contribution – you pay 50% or more, tied to a specific plan

New business rate guarantees – you enroll with a full 12-month rate and benefit guarantee

Workers' Compensation discount and potential Medical premium savings with Integrated MediComp

Additional savings opportunities when you purchase Life and Dental at the same time

Potential tax advantages for your company

Coverage is guaranteed ...

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.

... And you get tax advantages

Because health insurance premiums are treated as a general business expense, you may be able to deduct premiums and health benefit costs. (Ask your tax advisor about the unique advantages of the HSA-compatible plan included in this program.)

Get even more tax savings with 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.

EmployeeChoice At-a-Glance

- Five popular Blue Cross health plans (four PPOs and one HMO)
- Option to offer another carrier's HMO along with this package
- Ideal if you have employees who prefer a non-Blue Cross HMO
- Minimum of five employees enrolling in Blue Cross

Value



See Big Savings When You Offer Medical, Dental, Life, Vision and Workers' Compensation **Together**

At Blue Cross, we understand that you want to offer your employees a comprehensive benefits package while still keeping an eye on your budget. That's why we offer Medical, Dental, Life, Vision and Workers' Compensation.

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)*, Life coverage and Vision 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 from one convenient, reliable source.

*Employers Compensation Insurance Company is not affiliated with Blue Cross.

Watch the savings add up

Discounts & Savings

Choose how much you want to save:

- **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 coverage along with Medical (at the same time), you may qualify to receive up to a 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 Life coverage and any of our insured Dental plan(s) at the same time, and receive 6% savings on your Life premium and 6% savings on your Dental premium*
- **Composite Life Rates** – If your business enrolls 11 or more employees for Life coverage through BCL&H, you'll automatically receive our Composite Life rates. This means that your group will receive a single rate per \$1,000 of Life coverage, regardless of age and sex – so your older employees will pay the same rate as your younger employees. It adds up to easier administration and potentially cheaper rates for you.

And, with an ever-increasing number of workers developing eye strain, blurred vision and headaches due to using a computer, regular visits to an eye care provider are more important than ever. Offer Blue View Vision:SM

It's clear that our comprehensive health benefits package can play an integral role in managing the overall health and well-being of your employees. Why not offer them all?

*SmileNetSM Dental Discount Program does not qualify.



Five Blue Cross Plans

Five Plans + HMO Option = Maximum Flexibility.

EmployeeChoice is ideal if you have workers who prefer another carrier's HMO. Be sure to ask your Blue Cross agent how to offer another carrier's HMO side-by-side with this package.

This chart illustrates a member's payment for covered services. Covered services are subject to the annual deductible unless otherwise noted. Please refer to the Certificate and/or Combined Evidence of Coverage and Disclosure Form for comprehensive descriptions of coverage.

		Offered by Blue Cross of California (BCC)	Premier PPO \$20 Copay A high-end plan featuring rich benefits and the most comprehensive coverage.	PPO \$30 Copay* A top-selling, mid-range plan offering an ideal balance between cost and comprehensive benefits.
Annual Deductible			\$250 per member 2-member max	\$500 per member 2-member max
Annual Out-of-Pocket Maximum² Includes Annual Deductible	In-Network		\$3,000 per member 2-member max	\$4,000 per member 2-member max
	Out-of-Network		\$5,000 per member 2-member max	Blue Cross payments of \$10,000 per member's covered expenses
Office Visits	In-Network		First 12 visits per member: \$20 copay Additional visits: 40% of negotiated fee (not subject to deductible)	First 12 visits per member: \$30 copay Additional visits: 45% of negotiated fee (not subject to deductible)
	Out-of-Network		40% of customary & reasonable charges, plus 100% of excess charges (not subject to deductible)	50% of negotiated fee plus 100% of excess charges (not subject to deductible)
Professional Services Includes Maternity, Diagnostic Lab and X-ray	In-Network		20% of negotiated fee	30% of negotiated fee
	Out-of-Network		40% of customary & reasonable charges, plus 100% of excess charges	50% of negotiated fee plus 100% of excess charges

¹PPO 2400 Plan Annual Deductible and Annual Out-of-Pocket Maximum: Medical/pharmacy combined; in and out-of-network combined; certain payments do not apply.

² Annual Out-of-Pocket Maximum: Expenses that contribute to the maximum copayment limit vary from plan to plan and have restrictions and limitations. Refer to each plan's Combined Evidence of Coverage and Disclosure Form or Certificate for full details.

³ Per family amount is aggregate; i.e. if one or more family member's eligible covered expenses (combined) meet this amount, the requirement is satisfied for all covered family members.

HMO Flexibility

PPO \$35 Copay GenRx** A unique, generic-only prescription design allows this plan to provide comprehensive coverage at budget-friendly prices.	PPO 2400 (HSA-Compatible)** This plan combines health coverage, financial strategy options and HSA compatibility.	Saver HMO* This plan is ideal for those who want the simplicity and predictability of HMO coverage. ⁴
\$500 per member 2-member max	\$2,400 per member \$4,800 family aggregate ^{1,3}	\$1,500 per member Applies to inpatient and outpatient facility services, ambulatory surgical centers and dialysis centers except medical emergencies
\$4,000 per member 2-member max	\$3,600 per member \$5,500 family aggregate ^{1,3}	\$2,250 per member \$4,500 family aggregate ³
Blue Cross payments of \$10,000 per member's covered expenses	Member responsible for all charges over allowable amount when using a non-participating provider	Not covered
First 12 visits per member: \$35 copay Additional visits: 45% of negotiated fee (not subject to deductible)	\$35 copay	\$20 copay (not subject to deductible)
50% of negotiated fee plus 100% of excess charges (not subject to deductible)	50% of negotiated fee plus 100% of excess charges	Not covered
35% of negotiated fee	20% of negotiated fee	No charge except office visit copay for maternity services
50% of negotiated fee plus 100% of excess charges	50% of negotiated fee plus 100% of excess charges	Not covered

Plus
 Ability to offer another carrier's HMO

*Served by the Blue Cross HMO (CaliforniaCare) Network, available in most counties.

Continued on next page

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.

More Access



This chart illustrates a member's payment for covered services. Covered services are subject to the annual deductible, unless otherwise noted. Please refer to the Certificate and/or Combined Evidence of Coverage and Disclosure Forms for comprehensive descriptions of coverage.

		Premier PPO \$20 Copay*	PPO \$30 Copay*
<p>*Offered by Blue Cross of California (BCC)</p> <p>**Offered by BC Life & Health Insurance Company (BCL&H)</p>		A high-end plan featuring rich benefits and the most comprehensive coverage.	A top-selling, mid-range plan offering an ideal balance between cost and comprehensive benefits.
Emergency Care \$100 Emergency Room copayment for each visit – waived if admitted	In-Network	20% of negotiated fee	30% of negotiated fee
Hospital Inpatient and Outpatient	Participating Hospitals	20% of negotiated fee	30% of negotiated fee
Prescription Drugs Amounts shown are copays for each 30 day supply; up to a 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 ⁵	\$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) ⁶
Preventive Care	In-Network	\$20 office visit copay (not subject to deductible) plus 20% of negotiated fee for all other covered services	\$30 office visit copay (not subject to deductible) plus 30% of negotiated fee for all other covered services
HealthyCheckSM Screening Ages 7- Adult Not subject to deductible	In-Network	\$25 or \$75 copay health screening options	\$25 or \$75 copay health screening options
Annual Physical Exam Ages 7- Adult	In-Network	OR	Not covered
		\$20 office visit copay (not subject to deductible) plus 20% of negotiated fee for all other covered services ⁷	

⁵ Prescription Drugs: Members may select a brand-name drug when a generic drug is available if the physician writes, "dispense as written" or "do not substitute" prescription.

⁶ Prescription Drugs: If a member selects a brand-name drug when a generic equivalent drug is available, even if the physician writes "dispense as written" or "do not substitute" prescription, the member will be responsible for a generic copay plus the difference in cost between the brand-name drug and the generic equivalent drug. The amount does not apply to the member's brand-name deductible.

More Choice

PPO \$35 Copay GenRx** A unique, generic-only prescription design allows this plan to provide comprehensive coverage at budget-friendly prices.	PPO 2400 (HSA-Compatible)** This plan combines health coverage, financial strategy options and HSA compatibility.	Saver HMO* This plan is ideal for those who want the simplicity and predictability of HMO coverage. ⁴
35% of negotiated fee	20% of negotiated fee	No charge
35% of negotiated fee	20% of negotiated fee	No charge after deductible
\$15 generic; 30% of negotiated fee for generic self-administered injectable drugs, except insulin Note: This plan covers generic drugs only; call (800) 627-8797 to request the drug formulary list	\$10 generic; \$25 brand-name; 30% of negotiated fee for self-administered injectable drugs, except insulin ^{1, 5}	\$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) ⁶
\$35 office visit copay (not subject to deductible) plus 35% of negotiated fee for all other covered services	\$35 office visit copay (not subject to deductible) plus 20% of negotiated fee for all other covered services	\$20 copay
\$25 or \$75 copay health screening options	\$25 or \$75 copay health screening options	Not covered
Not covered	OR \$35 office visit copay (not subject to deductible) plus 20% of negotiated fee and 100% of excess charges for all covered services ⁷	Not covered

Plus
 Ability to offer another carrier's HMO

⁷ Annual Physical Exam: Maximum annual Blue Cross payment of \$200 for members covered more than six months; \$100 for members covered six months or less. Refer to each plan's Combined Evidence of Coverage and Disclosure Form or Certificate for full details.

Exclusions & Limitations

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 as a member 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.
- 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.
- Contraceptive devices unless your physician determines that oral contraceptive drugs are not medically appropriate.

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 a 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/Certificate.
- Conditions 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/Certificate.

General Provisions

Member Privacy

Our complete Notice of Privacy Practices provides a comprehensive overview of the policies and practices we enforce to preserve our members' privacy rights and control use of their health care information, including: the right to authorize release of information; the right to limit access to medical information; protection of oral, written and electronic information; use of data; and information shared with employers. This notice can be downloaded from our 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) 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 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.

General Provisions

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 Blue Cross (the Insurer) have failed to produce a satisfactory solution to the problem, you may wish to contact the CDI. They can be reached by writing to the CDI Consumer Affairs Bureau 300 South Spring St. - South Tower, Los Angeles, CA 90013. The CDI also has a toll-free phone number **(800) 927-HELP (4357)** that you may call for assistance.

Binding Arbitration

If the plan is subject to ERISA, any dispute involving 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 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 apply for 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 2004 was 80.14 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 Certificate and/or Combined Evidence of Coverage and Disclosure Form for comprehensive descriptions of coverage, benefits, special circumstances and limitations.

10 Things You Should Know About Generic Drugs

1. Brand-name drugs are protected by patents and supplied by single companies. When the patents expire, other manufacturers may apply to the U.S. Food and Drug Administration (FDA) to produce a generic version of these drugs.
2. Generic drugs are approved and regulated by the FDA. All generic drugs are put through a rigorous, multi-step approval process. From quality and performance to manufacturing and labeling, everything must meet the FDA's high standards.
3. A generic drug has the same strength, quality and performance as its brand-name counterpart.
4. Generic drugs must deliver the same amount of active ingredient (what makes the drug work) in the same timeframe as the brand-name drug.
5. Generic drugs are equal to brand-name drugs in terms of safety and effectiveness.
6. A generic drug is a copy that is the same as a brand-name drug in dosage form, how it is taken, and intended use.
7. The government monitors generic drugs as carefully as it does brand-name drugs.
8. In most cases, generic equivalents and generic alternatives can be safely used to treat the same condition as a brand-name drug.
9. Generic medications are less expensive because generic manufacturers don't have the investment costs that the developer of a new brand-name drug has. This allows generic drug makers to sell their product at substantial discounts.
10. By appropriately using more cost-effective generic medications, members can save money at the time of purchase and help control health care costs.



BlueCross
of California



BC Life & Health
Insurance Company



Blue Cross of California
Commercial HMO/PPO 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 (DOI). 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.

BCC offers the Saver HMO Plan, the Premier PPO \$20 Copay Plan, and the PPO \$30 Copay Plan. BCL&H offers the PPO \$35 Copay GenRx Plan and the PPO 2400 (HSA-Compatible) Plan. Dental plans offered by BCC and BCL&H. Life coverage and Vision coverage offered by BCL&H.

Workers' Compensation coverage offered by Employers Compensation Insurance Company. Administrative services for the Premium Only Plan (P.O.P.) are provided by Ceridian Corporation, an independent company that is not affiliated with BCC, its affiliates or parent organization.

Blue Cross of California
Small Group Services
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www.bluecrossca.com