LEADING **CHOICES**

Small Group EmployeeElect

PPO $30 Copay Plan

BlueCross
of California

Solutions at **Work**

Small Business Health Care Plans

Blue Cross … *coverage you can trust.*

With Blue Cross of California, you're getting much more than a health plan. You're getting the financial strength and stability of a company you can trust. You're getting our rock solid reputation and over 65 years of experience. And, because we strive to be customer-focused in everything we do, you'll have the security of knowing we'll be there when you need us. Just call Small Group Customer Service at (800) 627-8797 and we'll be happy to help.

PPO $30 Copay … comprehensive coverage with mid-range premiums, low deductibles and low office visit copays.

It's all about you.

- You get up to $5,000,000 in covered benefits over your lifetime
- You choose from over 46,000 doctors and specialists, and from over 440 hospitals
- You save money because we've negotiated lower rates with our in-network doctors
- You benefit from a HealthyCheck℠ preventive screening each year
- You get coverage all across the country through the BlueCard® program

Your plan is packed with valuable programs and services … Take advantage of these free resources:

- **HealthyExtensions℠** provides information about 10-50% discounts on health and wellness products and services offered by independent vendors and practitioners
- **MedCall®** connects you to registered nurses 24 hours a day for answers to your medical questions
- **Baby Connection℠** helps you take positive steps in preparing for your new arrival
- **Health Improvement Programs** support you in managing diabetes, asthma or congestive heart failure
- **Healthy Living** powered by WebMD provides a wealth of personalized information to assist with understanding and managing health issues, making responsible health care decisions and reaching your health care goals

Just the right balance between cost & coverage.

Powerful Savings *from The Power of Blue*[SM]

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

1) Our in-network doctors and hospitals charge you lower, Blue Cross-negotiated fees
2) You pay only a portion of the fees for your eligible covered expenses (see example below) and we pay the rest
3) We give you access to tremendous savings on preventive care, so you can stay as *healthy* as possible – and keep your health care expenses as *low* as possible

You're free to go to health care providers outside of the Blue Cross network, but you'll save a substantial amount by choosing from our ***46,000 doctors and 440 hospitals****.* ***So stay in the Blue Cross network …*** *and put The Power of Blue*[SM] *to work for you.*

One of our top-selling plans

The PPO $30 Copay Plan.

SMALL GROUP PPO $30 Copay Plan

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

CORE FEATURES	IN-NETWORK Receive Negotiated Savings	OUT-OF-NETWORK Pay Higher Costs
Annual Deductible In-network and out-of-network combined, annual deductible applies towards annual out-of-pocket maximum	**$500** per member for all medical services except office visits, HealthyCheck screenings and prescription drugs; two-member maximum	
Maximum Lifetime Covered Charges Paid by Blue Cross In-network and out-of-network combined	$5,000,000	
Annual Out-of-Pocket Maximum	**$4,000** per member, two-member maximum Certain member payments do not apply[1]	Once Blue Cross payments reach $10,000 per member, member pays nothing for covered expenses for the remainder of the year except charges over the allowed amounts
Office Visits Not subject to annual deductible	**$30** copay for initial 12 office visits per member, additional office visits **45%** of negotiated fee	**50%** of negotiated fee, plus **100%** of excess charges
Other Professional Services Includes maternity, diagnostic lab and X-ray	**30%** of negotiated fee after annual deductible	**50%** of negotiated fee, plus **100%** of excess charges after annual deductible
Hospital Inpatient Facility Services Preservice Review required	**30%** of negotiated fee after annual deductible	All charges in excess of $650 per day after annual deductible
Hospital Inpatient Professional Services (lab, physician, anesthesia)	**30%** of negotiated fee after annual deductible	**50%** of negotiated fee, plus **100%** of excess charges after annual deductible
Outpatient Facility Services Preservice Review required for certain services and procedures	**30%** of negotiated fee after annual deductible	All charges in excess of $380 per day after annual deductible
Ambulatory Surgical Centers Preservice Review required	**30%** of negotiated fee after annual deductible	All charges in excess of $380 per day after annual deductible
Prescription Drugs[2] 30-day supply retail; up to a 60-day supply available through mail order	Generic: **$15** copay Brand-name if generic not available: **$25** copay after annual **$150** brand-name prescription drug deductible Brand-name if generic is available: **$15** copay after annual **$150** brand-name prescription drug deductible **plus** the difference in cost between brand-name drug and generic equivalent Self-injectable (except insulin): **30%** of negotiated fee (subject to brand-name prescription drug deductible if applicable)	**50%** of drug limited fee schedule plus **100%** of excess charges if filled within California after annual **$150** brand-name prescription drug deductible per member, in-network and out-of-network combined
HealthyCheck℠ Screenings, Ages 7- Adult Includes certain lab tests, immunizations and health education information	***Not subject to annual deductible*** **$25** or **$75** copay health screening options	Not available

[1] *Services that do not apply to the annual out-of-pocket maximum include, but are not limited to: copay paid under the pharmacy benefit; copay paid for acupuncture/acupressure; copay for mental or nervous disorders and substance abuse (except for treatment of severe mental illness and serious emotional disturbances of a child); copay for not obtaining preservice review; HealthyCheck payments; $500 copay for infertility services; non-covered services.*

[2] *Infertility Drugs: Infertility drug lifetime maximum Blue Cross payment $1,500 in-network and out-of-network combined. All drug: if 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 paid does not apply to the member's brand-name deductible.*

SMALL GROUP PPO $30 Copay Plan

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

ADDITIONAL FEATURES	IN-NETWORK Receive Negotiated Savings	OUT-OF-NETWORK Pay Higher Costs
Well Baby Immunizations and Adult Screening Tests **Children through age 6** Regular check-up and immunizations **Ages 7-Adult** Includes annual Pap, breast exam, and mammogram for women and Prostate Specific Antigen study for men	**$30** copay for office visits (not subject to deductible); **30%** of negotiated fee for all other covered services after annual deductible	**50%** of negotiated fee, plus **100%** of excess charges after annual deductible
Emergency Care **$100** Emergency Room copayment for each visit – waived if admitted	**30%** of negotiated fee after annual deductible	**30%** of customary and reasonable charges, plus **100%** of excess charges for first 48 hours after annual deductible; after 48 hours, all charges in excess of $650 per day after annual deductible
Ambulance	**30%** of negotiated fee after annual deductible	**50%** of negotiated fee, plus **100%** of excess charges after annual deductible
Skilled Nursing Facility 100 days per year, in-network and out-of-network combined; Preservice Review required	**30%** of negotiated fee after annual deductible	All charges in excess of $150 per day after annual deductible
Home Health Care 100 four-hour visits per year, in-network and out-of-network combined; Preservice Review required	**30%** of negotiated fee after annual deductible	All charges in excess of $75 per visit after annual deductible
Physical/Occupational Therapy, Chiropractic Care 12 visits per year, in-network and out-of-network combined	**30%** of negotiated fee after annual deductible	All charges in excess of $25 per visit after annual deductible
Acupuncture/Acupressure 24 visits per year, in-network and out-of-network combined	All of the negotiated fee in excess of $25 per visit after annual deductible	All charges in excess of $25 per visit after annual deductible
Mental Health/Inpatient* Includes chemical dependency; 30 days per year, in-network and out-of-network combined; Preservice Review required	All of the negotiated fee in excess of $175 per day after annual deductible	All charges in excess of $175 per day after annual deductible
Mental Health/Outpatient Professional Services* Includes chemical dependency; One visit per day, 20 visits per year, in-network and out-of-network combined	All of the negotiated fee in excess of $25 per visit after annual deductible	All charges in excess of $25 per visit after annual deductible
Infusion Therapy Includes chemotherapy Preservice Review required	**30%** of negotiated fee after annual deductible	All charges in excess of $50 per day for all infusion therapy expenses except drugs; all charges in excess of the average wholesale price for all infusion therapy drugs; all charges in excess of the combined maximum Blue Cross payment of $500 per day; after annual deductible
Infertility Services Maximum lifetime Blue Cross payment $2,000, in-network and out-of-network combined	**$500** copay plus, **30%** of the balance of negotiated fee after annual deductible	**$500** copay plus **50%** of the balance of negotiated fee plus **100%** of excess charges after annual deductible

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

Exclusions and Limitations

Following is an abbreviated list of exclusions and limitations; please see the Combined Evidence of Coverage and Disclosure Form for comprehensive details.

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

General Provisions

Member Privacy

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

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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.

Binding Arbitration
If the plan is subject to ERISA, any dispute involving an adverse benefit decision must be resolved under ERISA claims procedure rules, and is not subject to mandatory binding arbitration. Members may pursue voluntary binding arbitration after they have completed an appeal under ERISA rules. If the member has another dispute that does not involve an adverse benefit decision, or if the group does not provide a plan that is subject to ERISA, the following provisions apply: Any 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.

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.

Blue Cross of California's PPO plans have once again received the highest accreditation possible from the National Committee for Quality Assurance (NCQA). This "Full" accreditation is in effect from November 23, 2005 through November 23, 2008. NCQA is an independent, non-profit organization whose mission is to improve health care quality everywhere, and its seal of approval empowers people to make informed decisions about their health care.

BlueCross of California

HealthyExtensions℠ and Baby Connection℠ are provided by Blue Cross as a service to our members. The *Web*MD Web site is owned and operated by *Web*MD Health Corp. *Web*MD Health Corp. is solely responsible for its Web site and is not affiliated with Blue Cross of California or any affiliate of Blue Cross of California. This service does not constitute benefits under Blue Cross plans and is subject to change or cancellation without notice. Goods and services available through discount programs are not benefits of coverage. Blue Cross does not endorse or recommend any goods or services provided at a discount by these vendors or practitioners. These programs may be changed or withdrawn at any time without notice by the offering vendor or practitioner.

Blue Cross of California (BCC) is an Independent Licensee of the Blue Cross Association (BCA). BCC is a health care service plan regulated by the Department of Managed Health Care. The Power of Blue is a service mark and the Blue Cross name, symbol and BlueCard are registered service marks of the BCA.

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