



BC Life & Health
Insurance Company

Small Group EmployeeElect

Power HealthFund 750 Plan



Solutions

Small Business Health Care Plans

at **Work**

Blue Cross ... coverage you can trust.

With Blue Cross, 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.

Power HealthFund 750 ... first-dollar coverage provides immediate benefits before the deductible is met.

It's all about you.

- You get \$750 of coverage *before* satisfying your annual deductible
- 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 HealthyCheckSM preventive screening each year
- You get coverage all across the country through the BlueCard[®] program

How the Power HealthFund 750 works ...

Each year, members are allowed a set dollar amount of first-dollar coverage to spend on covered health services *before* they are required to satisfy an annual medical deductible. For many members, the plan's first-dollar coverage is sufficient to cover an average year's medical expenses.

If the member has been enrolled prior to the last quarter of the year and there are first-dollar funds left over at the end of the year, the left-over funds automatically roll over to the next year. Balances can be rolled over to a maximum of two times the first-dollar coverage amount (e.g., \$750 x 2 = \$1,500). This could provide members with even more first-dollar coverage.

Plus, for families, there are no restrictions on how much of the first-dollar coverage each member can use. If one member needs it all, that member can use it all – including the rollover from the previous year.

Your plan is packed with valuable programs and services ...

Take advantage of these free resources:

- **HealthyExtensionsSM** provides information about 10-50% discounts on health and wellness products and services from independent vendors and practitioners
- **MedCall[®]** connects you to registered nurses 24 hours a day for answers to your medical questions
- **Baby ConnectionSM** 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** gives you access to a wealth of information and resources on www.bluecrossca.com
- **Subimo[®] Healthcare Advisor** offers you the ability to research medical and hospital information customized to your specific circumstances through access to their convenient and secure Web site

Moderately Priced Premiums
Comprehensive 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

First-dollar coverage gives you more control over your health care budget.

With careful budgeting, your first-dollar coverage can last a long time. You decide how much to spend, and how fast to spend it. It is available for immediate use to pay for all covered medical services (except prescription drugs). By using in-network providers, your first-dollar coverage stretches even further because of Blue Cross- negotiated savings.

SERVICES (DATE)	TYPE OF SERVICE	TOTAL BILLED	AMOUNT NOT ALLOWED	PATIENT SAVINGS	APPLIED TO DEDUCTIBLE	CONSUMABLE CONTAINMENT AMOUNT	BILL (DROSS) AMOUNT
07/06/2006-07/06/2006	INPATIENT SERVICES	\$5,190.00		\$2,840.00		\$235.00	\$2,115.00
TOTAL THIS CLAIM		\$5,190.00	\$0.00	\$2,840.00	\$0.00	\$235.00	\$2,115.00

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.**

Immediate Benefits

The Power HealthFund 750 features a **simple and unique benefit design** that keeps costs moderate – while providing comprehensive PPO coverage. The key is first-dollar (immediate) coverage coupled with an annual medical deductible.

SMALL GROUP Power HealthFund 750 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
First-Dollar Coverage In-network and out-of-network combined; available for immediate use to pay for all covered services EXCEPT prescription drugs; amounts paid will not apply toward annual deductible or maximum copayment limits	Single member: \$750 Family contract ¹ : \$1,500 aggregate	
Annual Deductible In-network and out-of-network combined; deductible accrues after first-dollar coverage is exhausted	Single member: \$500 Family contract ¹ : \$1,000 aggregate	
Maximum Lifetime Covered Charges Paid by Blue Cross In-network and out-of-network combined	\$5,000,000	
Annual Out-of-Pocket Maximum Per family amount is aggregate, i.e., when one or more family members' eligible covered expenses (combined) meet this amount, the requirement is satisfied for all covered family members	Single member: \$5,000 Family contract ¹ : \$10,000 aggregate Certain member payments do not apply ²	Once Blue Cross payments reach \$10,000 for a single member or \$20,000 aggregate for a family contract ¹ , members pay nothing for covered expenses for the remainder of the year except charges over the allowed amounts ²
Office Visits No maximum visits	\$35 copay ³	50% of negotiated fee ³ plus 100% of excess charges
Other Professional Services Includes maternity, diagnostic lab and X-rays	25% of negotiated fee ³	50% of negotiated fee ³ plus 100% of excess charges
Hospital Inpatient Facility Services Preservice Review required	25% of negotiated fee ³	All charges in excess of \$650 per day ³
Hospital Inpatient Professional Services (lab, physician, anesthesia)	25% of negotiated fee ³	50% of negotiated fee ³ plus 100% of excess charges
Outpatient Facility Services Preservice Review required for certain surgical services and diagnostic procedures	25% of negotiated fee ³	All charges in excess of \$380 per day ³
Ambulatory Surgical Centers Preservice Review required	25% of negotiated fee ³	All charges in excess of \$380 per day ³
Prescription Drugs⁴ 30-day supply retail; up to a 60-day supply available through mail-order	Generic: \$10 copay; brand-name if generic not available: \$30 copay after annual \$250 brand-name prescription drug deductible; brand-name if generic is available: \$10 copay after annual \$250 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 \$250 brand-name prescription drug deductible per member, in-network and out-of-network combined
HealthyCheckSM 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 Family contract consists of two (2) or more enrolled members.

² 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 and nervous disorders and substance abuse (except for treatment of severe mental illness and serious emotional disturbances of a child) whether performed by a participating or non-participating provider; copay for not obtaining preservice review; \$500 copay for infertility services; non-covered services and copay made to non-participating providers.

³ Blue Cross will pay covered services (except prescription drug copays) at 100 percent of covered expense up to the first-dollar coverage maximum. After first-dollar coverage has been exhausted, the annual deductible must be satisfied before Blue Cross will pay for subsequent covered services.

SMALL GROUP Power HealthFund 750 Plan

This is an overview of coverage. A comprehensive description of coverage, benefits and limitations is contained in the Certificate. 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 (PSA) study for men	\$35 copay for office visit; 25% of negotiated fee for all other covered services ³ Copayments do not apply to deductible	50% of negotiated fee ³ plus 100% of excess charges
Emergency Care \$100 Emergency Room copayment for each visit – waived if admitted	25% of negotiated fee ³	25% of customary and reasonable charges plus 100% of excess charges for first 48 hours; after 48 hours, all charges in excess of \$650 per day ³
Ambulance	25% of negotiated fee ³	50% of negotiated fee ³ plus 100% of excess charges
Skilled Nursing Facility 100 days per year, in-network and out-of-network combined; Preservice Review required	25% of negotiated fee ³	All charges in excess of \$150 per day ³
Home Health Care 100 four-hour visits per year; in-network and out-of-network combined; Preservice Review required	25% of negotiated fee ³	All charges in excess of \$75 per visit ³
Physical/Occupational Therapy, Chiropractic Care 12 visits per year, in-network and out-of-network combined	25% of negotiated fee ³	All charges in excess of \$25 per visit ³
Acupuncture/Acupressure 12 visits per year, in-network and out-of-network combined; does not apply to out-of-pocket maximum	All of the negotiated fee in excess of \$25 per visit ³	All charges in excess of \$25 per visit ³
Mental Health/Inpatient⁵ Includes chemical dependency 30 days per year, in-network and out-of-network combined; copayments do not apply to out-of-pocket maximum	All of the negotiated fee in excess of \$175 per day ³	All charges in excess of \$175 per day ³
Mental Health/Outpatient professional services⁵ Includes chemical dependency One visit per day, 20 visits per year, in-network and out-of-network combined; copayments do not apply to out-of-pocket maximum	All of the negotiated fee in excess of \$25 per visit ³	All charges in excess of \$25 per visit ³
Infusion Therapy Includes chemotherapy Preservice Review required	25% of negotiated fee ³	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 ³
Infertility Services Maximum lifetime Blue Cross payment \$2,000, in-network and out-of-network combined	\$500 copay plus 25% of the balance of negotiated fee ³	\$500 copay plus 50% of the balance of negotiated fee plus 100% of charges in excess of negotiated fee ³

⁴ Infertility Drugs: Infertility drug lifetime maximum Blue Cross payment \$1,500 in-network and out-of-network combined. All drugs: if a member selects a brand-name drug when a generic equivalent is available, even if the physician writes "dispense as written" or "do not substitute" on the prescription, the member will be responsible for the generic copay plus the difference in cost between the brand-name drug and the generic equivalent. None of the amount paid applies to the member's brand-name drug deductible.

⁵ 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 Certificate for comprehensive details.

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

- Private duty nursing except as specifically stated in the 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.

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

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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 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 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 and B of Medicare, you will be eligible for non-duplicate Medicare coverage, with supplemental coordination of benefits. However, if you are required to pay the Social Security Administration an additional premium for any part of Medicare, then the above policy will only apply if you are enrolled in that part of Medicare. Note: Medicare-eligible employees/dependents enrolled in plans where Medicare is primary may obtain an Individual 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.

Easy and Predictable

The Power HealthFund 750 Plan works in three simple steps:

Step 1 – Use first-dollar coverage

First, the plan offers \$750 in first-dollar coverage for single members and \$1,500 for two or more members.

Step 2 – Satisfy medical deductible

After using the first-dollar coverage, you must satisfy a \$500 medical deductible for single members or a \$1,000 deductible for two or more members.

Step 3 – Coinsurance/office visit copays take over

After the medical deductible is met, the plan immediately begins paying a specific percentage (coinsurance) for covered services except office visits, which are covered by a predictable copayment instead of coinsurance.

Benefit Payment Example: Single Member with Power HealthFund 750 Plan

	1 Step 1: First-Dollar Coverage (First \$750)	2 Step 2: Medical Deductible (Next \$500)	3 Step 3: Coinsurance/ Office Visit Copays Take Over
Member pays	\$0*	100%	25% coinsurance \$35 office visit copay
Plan pays	\$750	\$0	75% coinsurance

**First-dollar coverage cannot be used to pay for prescription drugs. Drug coverage under the plans requires that members pay for generic prescription drug copays and satisfy an annual brand-name prescription drug deductible first before they are eligible for brand-name copays.*



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HealthyExtensionsSM and Baby ConnectionSM are provided by Blue Cross as a service to our members. 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.

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