



BlueCross
of California



BC Life & Health
Insurance Company

HIPAA Plans

Health Insurance Portability and Accountability Act of 1996

Effective January 1, 2007

www.bluecrossca.com



KEEPING CALIFORNIANS COVERED

Blue Cross HIPAA plans can keep you covered when coverage through an employer-sponsored plan ends. Coverage is guaranteed under one of our HIPAA plans for anyone who qualifies.

Are you eligible?

To qualify for a HIPAA plan, you must:

- have completed a minimum of 18 months of continuous health coverage, most recently under an employer-sponsored group health plan;
- have elected and exhausted continuation of coverage under COBRA or Cal-COBRA, if available;
- have lost coverage within the last 63 days;* and
- not be eligible for Medi-Cal or Medicare, or have any other medical coverage.

** For reasons other than fraud or non-payment of premiums.*

Do you meet enrollment requirements?

To enroll, you must be a permanent legal resident of California and one of the following;

- the applicant's spouse or qualified Domestic Partner who is not Medicare eligible;
- the applicant's children (under 19 years of age), or the children (under 19 years of age) of the enrolling applicant's spouse or qualified Domestic Partner
- the applicant's unmarried dependent child between the ages of 19 and 23 ("dependent" as defined by the Internal Revenue Service).

What are your HIPAA plan choices?

From Blue Cross of California:

- **HIPAA PPO Share 1500 (R416)**
Featuring a \$1,500 annual deductible
- **HIPAA PPO Share 2500 (R415)**
Featuring a \$2,500 annual deductible

From BC Life & Health Insurance Company:

- **BC Life & Health HIPAA PPO Share 5000 (R417)**
Featuring a \$5,000 annual deductible
- **BC Life & Health HIPAA Basic PPO 1000 (PE02)**
A limited plan featuring a \$1,000 annual deductible

HIPAA PLANS: OVERVIEW OF COVERAGE ... and your share of costs

2

Your Plan Features	HIPAA PPO Share 1500 (R416)		HIPAA PPO Share 2500 (R415)	
	Participating Provider	Non-participating Provider	Participating Provider	Non-participating Provider
Lifetime Maximum	\$5,000,000		\$5,000,000	
Annual Out-of-Pocket Maximum <i>(includes deductible)</i>	\$6000/ single (2-member maximum); participating and non-participating combined ¹		\$7500/ single (2-member maximum); participating and non-participating combined ¹	
Annual Deductible <i>(applies to above Out-of-Pocket Maximum)</i>	\$1,500/single (2-member maximum); all covered benefits		\$2,500/single (2-member maximum); all covered benefits	
Office Visits	30% of negotiated fee <i>(deductible waived)</i>	50% of negotiated fee plus excess for covered expenses <i>(deductible waived)</i>	30% of negotiated fee <i>(deductible waived)</i>	50% of negotiated fee plus excess for covered expenses <i>(deductible waived)</i>
Professional Services <i>(X-ray, lab, anesthesia, surgeon, etc.)</i>	30% of negotiated fee	50% of negotiated fee plus excess for covered expenses	30% of negotiated fee	50% of negotiated fee plus excess for covered expenses
Hospital Inpatient/Outpatient	30% of negotiated fee ²	All charges except \$650/day inpatient, \$380/day outpatient	30% of negotiated fee ²	All charges except \$650/day inpatient, \$380/day outpatient
Emergency Services	30% of negotiated fee ⁴	30% of customary & reasonable charges for the first 48 hours plus 100% of excess; after 48 hours, you pay all charges except \$650/day for covered services ⁴	30% of negotiated fee ⁴	30% of customary & reasonable charges for the first 48 hours plus 100% of excess; after 48 hours, you pay all charges except \$650/day for covered services ⁴
Maternity	30% of negotiated fee	50% of negotiated fee plus 100% of excess	30% of negotiated fee	50% of negotiated fee plus 100% of excess
Preventive Care	Routine mammogram, Pap and PSA tests, ordered by a physician: 30% of negotiated fee <i>(deductible waived)</i> ; Well-child: 40% of negotiated fee through age 6 <i>(deductible waived)</i> HealthyCheck SM Centers: \$25 or \$75 copay for basic screenings	Routine mammogram, Pap and PSA ordered by physician: 50% of negotiated fee plus excess <i>(deductible waived)</i> ; Well-child: 50% of negotiated fee through age 6 <i>(deductible waived)</i>	Routine mammogram, Pap, and PSA tests, ordered by a physician: 30% of negotiated fee <i>(deductible waived)</i> ; Well-child: 40% of negotiated fee through age 6 <i>(deductible waived)</i> HealthyCheck SM Centers: \$25 or \$75 copay for basic screenings	Routine mammogram, Pap and PSA ordered by physician: 50% of negotiated fee plus excess <i>(deductible waived)</i> Well-child: 50% of negotiated fee through age 6 <i>(deductible waived)</i>
Drug Benefits* <i>(Retail or Mail Order: 30-day supply)</i>	Blue Cross Formulary Drugs: ⁶ \$10 generic, \$30 brand-name copay after \$250 brand-name deductible ⁵ (2-member maximum); 30% of negotiated fee for self-administered injectables except insulin	Blue Cross Formulary Drugs: ⁶ 50% of generic or 50% of brand-name Drug Limited-Fee Schedule within California; \$250 brand-name deductible	Blue Cross Formulary Drugs: ⁶ \$10 generic, \$30 brand copay after \$500 brand-name deductible ⁵ (2-member maximum); 30% of negotiated fee for self-administered injectables except insulin	Blue Cross Formulary Drugs: ⁶ 50% of generic or 50% of brand-name Drug Limited-Fee Schedule within California; \$500 brand-name deductible

A more detailed listing of coverage can be found in the Evidence of Coverage/Certificate booklet. For a copy, call your agent or Blue Cross of California at 800-333-0912.

(after deductible)

BC Life HIPAA PPO Share 5000 (R417)		BC Life HIPAA Basic PPO 1000 (PE02)	
Participating Provider	Non-participating Provider	Participating Provider	Non-participating Provider
\$5,000,000		\$5,000,000	
\$7,500/single (2-member maximum); participating and non-participating combined ¹		\$3,500/single, only hospital costs apply (2-member maximum); participating and non-participating combined ¹	
\$5,000/single (2-member maximum)		\$1,000 single, inpatient or surgical procedures only (2-member maximum); all covered benefits	
30% of negotiated fee for office visits (deductible waived)	50% of negotiated fee plus excess for covered expenses (deductible waived)	No office visit benefit until out-of-pocket maximum is met, then covered at 100% of negotiated fee	No office visit benefit until out-of-pocket maximum is met, then covered at 50% of negotiated fee plus excess for covered expenses
30% of negotiated fee	50% of negotiated fee plus excess for covered expenses	20% of negotiated fee, inpatient or surgical procedures only. No office visit benefits until out-of-pocket maximum is met, then covered at 100% of negotiated fee	50% of negotiated fee, inpatient or surgical procedures. plus excess for covered expenses
30% of negotiated fee ²	All charges except \$650/day inpatient, \$380/day outpatient	20% of negotiated fee ²	All charges except: \$650/day inpatient, \$380/day outpatient
30% of negotiated fee ⁴	30% of customary & reasonable charges for the first 48 hours plus 100% of excess; after 48 hours, member pays all charges except \$650/day for covered services ⁴	20% of negotiated fee ³	20% of customary & reasonable for the first 48 hours plus 100% of excess; after 48 hours, you pay all charges except \$650/day for covered services ³
30% of negotiated fee	50% of negotiated fee plus 100% of excess	Not Covered	Not Covered
Routine mammogram, Pap, and PSA tests: 30% of negotiated fee (deductible waived) Well Child: 40% of negotiated fee through age 6 (deductible waived) HealthyCheck Centers: \$25 or \$75 copay for basic screenings	Routine mammogram, Pap, and PSA tests: 50% of negotiated fee plus excess (deductible waived) Well Child: 50% of negotiated fee through age 6 (deductible waived)	Routine mammogram, Pap, and PSA ordered by a physician: 20% of negotiated fee (deductible waived) HealthyCheck SM Centers: \$25 or \$75 copay for basic screenings	Routine mammogram, Pap, and PSA ordered by a physician: 50% of negotiated fee plus excess (deductible waived)
Blue Cross Formulary Drugs: ⁶ \$10 generic; \$35 brand-name copay after \$750 brand-name deductible ⁵ (2-member maximum); 30% of negotiated fee for self-administered injectables, except insulin	Blue Cross Formulary Drugs: ⁶ 50% generic or 50% of brand-name Drug Limited Fee Schedule within California; \$750 brand-name deductible	Not Covered	Not Covered

3

¹ Non-participating charges in excess of the negotiated fee will not be paid and do not apply to the out-of-pocket maximum.

² Additional \$500 admission charge at Participating Hospital (no additional charge for Preferred Participating Hospitals) is for surgery or infusion therapy. This charge is not required for Ambulatory Surgical Centers or medical emergencies.

³ Additional \$30 copay applies for each emergency room visit (waived if admitted as inpatient).

⁴ Additional \$100 copay applies for each emergency room visit (waived if admitted as inpatient).

⁵ Brand-name drug deductible does not apply to out-of-pocket maximum.

⁶ Non-Formulary Drugs: You pay 50% for generic; 100% for brand-name up to brand-name deductible amount. After that you pay 50% for brand if no generic is available or you pay the generic copay plus the cost difference between the brand name and available generic equivalent drug.

* If a member selects a brand-name drug when a generic equivalent is available, then he or she will pay the generic copay plus the cost difference between the brand-name and available generic equivalent drug, even if the physician writes "dispense as written" or "do not substitute" on the prescription. The amount paid does not apply to the member's brand-name deductible.

WHAT THE MEDICAL PLANS DO NOT COVER

Every health plan has exclusions and limitations that describe what the plans do not cover. General exclusions and limitations are listed below for the health plans described in this brochure. Please take a few moments to review these listings. We want you to understand what your coverage does not include before you enroll. These listings are an overview only. Plan-specific Evidence of Coverage and Disclosure Form/Certificate booklets contain a comprehensive list of each plan's exclusions and limitations. For a sample copy of an Evidence of Coverage and Disclosure Form/Certificate booklet, ask your agent or contact us.

Exclusions and Limitations

4

- Conditions covered by workers' compensation or similar law.
- Experimental or investigative services.
- Services provided by a local, state, federal or foreign government, unless you have to pay for them.
- Services or supplies not specifically listed as covered under the plan agreement.
- Services received before your effective date.
- Services received after coverage ends.
- Services you wouldn't have to pay for without insurance.
- Services from relatives.
- Any services received by Medicare benefits without payment of additional premium.
- Services or supplies that are not medically necessary.
- Routine physical exams, except for preventive care services (e.g., physical exams for insurance, employment, licenses or school are not covered)
- Any amounts in excess of the maximum amounts listed in the Evidence of Coverage and Disclosure Form/Certificate.
- Sex changes.
- Cosmetic surgery.
- Services primarily for weight reduction except medically necessary treatment of morbid obesity.
- Dental care, dental implants or treatment to the teeth, except as specifically stated in the Evidence of Coverage and Disclosure Form/Certificate.
- Hearing aids.
- Contraceptive drugs and/or certain contraceptive devices, except as specifically stated in the Evidence of Coverage and Disclosure Form/Certificate.
- Infertility services.
- Private duty nursing.
- Eyeglasses or contact lenses, except as specifically stated in the Evidence of Coverage and Disclosure Form/Certificate.
- Vision care including certain eye surgeries to replace glasses, except as specifically stated in the Evidence of Coverage and Disclosure Form/Certificate.
- Mental and nervous disorders and substance abuse, except as specifically stated in the Evidence of Coverage and Disclosure Form/Certificate.
- Certain orthopedic shoes or shoe inserts, except as specifically stated in the Evidence of Coverage and Disclosure Form/Certificate.
- Outdoor treatment programs.
- Telephone or facsimile machine consultations.
- Educational services except as specifically provided or arranged by Blue Cross.
- Nutritional counseling
- Food or dietary supplements, except for formulas and special food products to prevent complications of phenylketonuria (PKU).
- Care or treatment furnished in a non-contracting hospital, except as specifically stated in the Evidence of Coverage and Disclosure Form/Certificate.

- *Personal comfort items.*
- *Custodial care.*
- *Certain genetic testing.*
- *Outpatient speech therapy, except as specifically stated in the Evidence of Coverage and Disclosure Form/Certificate.*
- *Any amounts in excess of maximums stated in the Combined Evidence of Coverage and Disclosure Form/Certificate.*
- *Services or supplies supplied to any person not covered under the Agreement in connection with a surrogate pregnancy.*
- *Outpatient drugs, medications or other substances dispensed or administered in any outpatient setting.*

5

Additional Exclusions and Limitations for the BC Life HIPAA Basic PPO 1000 Only

- *Maternity or pregnancy care.*
- *Preventive benefits, except for Pap and PSA tests, and mammograms, not specifically listed in the Certificate*
- *Outpatient prescription drugs.*
- *Acupuncture/Acupressure*
- *Physician office visits and associated costs, except as specifically described in the Certificate.*
- *Physical or occupational medicine or chiropractic services, except those provided during an inpatient hospital confinement.*
- *Eye glasses and eye examinations.*

RIGHTS AND OBLIGATIONS

No-Obligation Review Period

After you enroll in a Blue Cross health plan, you will receive an Evidence of Coverage/Certificate booklet that explains the exact terms and conditions of coverage, including the plan's exclusions and limitations. You have 10 full days to examine your plan's features. During that time, if you are not fully satisfied, you may decline by returning your Evidence of Coverage/Certificate booklet along with a letter notifying us that you wish to discontinue coverage. Evidence of Coverage/Certificate booklets are available for you to examine prior to enrolling. Ask your agent or Blue Cross.

Once you enroll in a Blue Cross HIPAA plan, you will have 30 days from the date of enrollment to change to a different HIPAA plan. Your effective date will be the same as the date of your original enrollment. No further changes will be allowed after you have been enrolled for 30 days.

Guarding Your Privacy

Blue Cross is fully committed to protecting our members' 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. You may obtain our complete **Notice of Privacy Practices** from our Web site at www.bluecrossca.com. You may also call the Customer Service number listed on your member ID card, or prospective members may call 1-800-333-0912.

Requirements for Binding Arbitration

If you are applying for coverage, please note that Blue Cross requires binding arbitration to settle all disputes, including claims of medical malpractice. California Health and Safety Code Section 1363.1 and Insurance Code Section 10123.19 require specified disclosures in this regard, including the following notice: "It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration." Both parties also agree to give up any right to pursue on a class basis any claim or controversy against the other.

Grievances

All complaints and disputes relating to your coverage must be resolved in accordance with Blue Cross' grievance procedure. Grievances may be made by telephone or in writing; the phone number and address are located in your Evidence of Coverage/Certificate and Disclosure Form. All grievances received by Blue Cross will be answered in writing, together with a description of how Blue Cross proposes to resolve the grievance.

Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans, including Blue Cross of California (but not BC Life & Health). If you have a grievance against your health plan, you should first telephone your health plan at (800) 333-0912 and use your health plan's grievance process before contacting the department. 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 department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for an 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 department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's Internet Web site (<http://www.hmoHELP.ca.gov>) has complaint forms, IMR application forms and instructions on-line.

Third-Party Liability

Blue Cross of California is entitled to reimbursement of benefits paid if you recover damages from a legally liable third party. Examples of third-party liability situations include car accidents and work-related injuries. For complete information about third-party liability, refer to the plan Evidence of Coverage/Certificate booklet.

Incurred Medical Care Ratio

As required by law, we are advising you that Blue Cross of California's incurred medical care loss ratio for 2004 was 80.14 percent. This loss ratio was calculated after provider discounts were applied.

MONTHLY RATES

Rates for the Blue Cross of California and BCL&H Individual HIPAA Plans are based upon the county in which you reside, and your family status and age. For Subscriber & Spouse and Family, rates are based on the age of the younger spouse. To determine your rate, find your county in the Rating Areas chart below and the rate for your area and category on the rate tables. Rates are recalculated at each billing period based on age and the residence address.

Rating Areas

Area 1: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Mendocino, Modoc, Mono, Monterey, Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo, Yuba

Area 2: Fresno, Imperial, Kern, Madera, Mariposa, Merced, Napa, Sacramento, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Sonoma, Stanislaus

7

Area 3: Alameda, Contra Costa, Marin, San Francisco, San Mateo, Santa Clara

Area 4: Orange, Santa Barbara, Ventura

Area 5: Los Angeles

Area 6: Riverside, San Bernardino, San Diego

Payment Methods

You may choose one of the following payment methods:

- Monthly billing—available with Monthly Checking Account Automatic Premium Payment Authorization only
- Bimonthly (two-month) billing
- Quarterly (three-month) billing

See page 3 of the application for instructions regarding your first premium payment.

MONTHLY RATES EFFECTIVE 1-1-07

Age Range		HIPAA PPO Share 2500 (R415)						Age Range		HIPAA PPO Share 1500 (R416)					
		Area 1	Area 2	Area 3	Area 4	Area 5	Area 6			Area 1	Area 2	Area 3	Area 4	Area 5	Area 6
Single	<15	\$223	\$207	\$206	\$221	\$219	\$200	Single	<15	\$223	\$207	\$206	\$221	\$219	\$200
	15-29	\$296	\$281	\$279	\$283	\$284	\$260		15-29	\$296	\$281	\$279	\$283	\$284	\$260
	30-34	\$390	\$360	\$360	\$363	\$368	\$333		30-34	\$390	\$360	\$360	\$363	\$368	\$333
	35-39	\$433	\$396	\$391	\$403	\$411	\$371		35-39	\$433	\$396	\$391	\$403	\$411	\$371
	40-44	\$513	\$457	\$457	\$468	\$474	\$422		40-44	\$513	\$457	\$457	\$468	\$474	\$422
	45-49	\$580	\$514	\$512	\$529	\$535	\$471		45-49	\$580	\$514	\$512	\$529	\$535	\$471
	50-54	\$714	\$621	\$621	\$639	\$652	\$574		50-54	\$714	\$621	\$621	\$639	\$652	\$574
	55-59	\$869	\$746	\$740	\$774	\$790	\$689		55-59	\$869	\$746	\$740	\$774	\$790	\$689
60-64	\$928	\$799	\$807	\$816	\$818	\$707	60-64	\$928	\$799	\$807	\$816	\$818	\$707		
Subscriber & Spouse	15-29	\$760	\$685	\$677	\$690	\$706	\$622	Subscriber & Spouse	15-29	\$760	\$685	\$677	\$690	\$706	\$622
	30-34	\$879	\$793	\$783	\$803	\$823	\$723		30-34	\$879	\$793	\$783	\$803	\$823	\$723
	35-39	\$971	\$870	\$859	\$880	\$909	\$800		35-39	\$971	\$870	\$859	\$880	\$909	\$800
	40-44	\$1,037	\$930	\$934	\$948	\$973	\$857		40-44	\$1,037	\$930	\$934	\$948	\$973	\$857
	45-49	\$1,156	\$1,022	\$1,027	\$1,052	\$1,083	\$938		45-49	\$1,156	\$1,022	\$1,027	\$1,052	\$1,083	\$938
	50-54	\$1,409	\$1,232	\$1,244	\$1,267	\$1,303	\$1,133		50-54	\$1,409	\$1,232	\$1,244	\$1,267	\$1,303	\$1,133
	55-59	\$1,675	\$1,447	\$1,446	\$1,501	\$1,543	\$1,344		55-59	\$1,675	\$1,447	\$1,446	\$1,501	\$1,543	\$1,344
	60-64	\$1,768	\$1,547	\$1,555	\$1,579	\$1,609	\$1,384		60-64	\$1,768	\$1,547	\$1,555	\$1,579	\$1,609	\$1,384
Subscriber & Child	15-29	\$760	\$685	\$677	\$690	\$706	\$622	Subscriber & Child	15-29	\$760	\$685	\$677	\$690	\$706	\$622
	30-34	\$879	\$793	\$783	\$803	\$823	\$723		30-34	\$879	\$793	\$783	\$803	\$823	\$723
	35-39	\$971	\$870	\$859	\$880	\$909	\$800		35-39	\$971	\$870	\$859	\$880	\$909	\$800
	40-44	\$1,037	\$930	\$934	\$948	\$973	\$857		40-44	\$1,037	\$930	\$934	\$948	\$973	\$857
	45-49	\$1,156	\$1,022	\$1,027	\$1,052	\$1,083	\$938		45-49	\$1,156	\$1,022	\$1,027	\$1,052	\$1,083	\$938
	50-54	\$1,409	\$1,232	\$1,244	\$1,267	\$1,303	\$1,133		50-54	\$1,409	\$1,232	\$1,244	\$1,267	\$1,303	\$1,133
	55-59	\$1,675	\$1,447	\$1,446	\$1,501	\$1,543	\$1,344		55-59	\$1,675	\$1,447	\$1,446	\$1,501	\$1,543	\$1,344
	60-64	\$1,768	\$1,547	\$1,555	\$1,579	\$1,609	\$1,384		60-64	\$1,768	\$1,547	\$1,555	\$1,579	\$1,609	\$1,384
Family	15-29	\$1,088	\$1,012	\$1,005	\$1,070	\$1,088	\$992	Family	15-29	\$1,088	\$1,012	\$1,005	\$1,070	\$1,088	\$992
	30-34	\$1,272	\$1,194	\$1,188	\$1,219	\$1,246	\$1,124		30-34	\$1,272	\$1,194	\$1,188	\$1,219	\$1,246	\$1,124
	35-39	\$1,356	\$1,253	\$1,251	\$1,279	\$1,327	\$1,180		35-39	\$1,356	\$1,253	\$1,251	\$1,279	\$1,327	\$1,180
	40-44	\$1,465	\$1,331	\$1,332	\$1,353	\$1,390	\$1,232		40-44	\$1,465	\$1,331	\$1,332	\$1,353	\$1,390	\$1,232
	45-49	\$1,571	\$1,397	\$1,395	\$1,447	\$1,489	\$1,293		45-49	\$1,571	\$1,397	\$1,395	\$1,447	\$1,489	\$1,293
	50-54	\$1,817	\$1,595	\$1,600	\$1,637	\$1,696	\$1,471		50-54	\$1,817	\$1,595	\$1,600	\$1,637	\$1,696	\$1,471
	55-59	\$2,100	\$1,788	\$1,788	\$1,876	\$1,927	\$1,646		55-59	\$2,100	\$1,788	\$1,788	\$1,876	\$1,927	\$1,646
	60-64	\$2,261	\$1,933	\$1,918	\$1,980	\$2,052	\$1,754		60-64	\$2,261	\$1,933	\$1,918	\$1,980	\$2,052	\$1,754
Subscriber & Children	15-29	\$1,088	\$1,012	\$1,005	\$1,070	\$1,088	\$992	Subscriber & Children	15-29	\$1,088	\$1,012	\$1,005	\$1,070	\$1,088	\$992
	30-34	\$1,272	\$1,194	\$1,188	\$1,219	\$1,246	\$1,124		30-34	\$1,272	\$1,194	\$1,188	\$1,219	\$1,246	\$1,124
	35-39	\$1,356	\$1,253	\$1,251	\$1,279	\$1,327	\$1,180		35-39	\$1,356	\$1,253	\$1,251	\$1,279	\$1,327	\$1,180
	40-44	\$1,465	\$1,331	\$1,332	\$1,353	\$1,390	\$1,232		40-44	\$1,465	\$1,331	\$1,332	\$1,353	\$1,390	\$1,232
	45-49	\$1,571	\$1,397	\$1,395	\$1,447	\$1,489	\$1,293		45-49	\$1,571	\$1,397	\$1,395	\$1,447	\$1,489	\$1,293
	50-54	\$1,817	\$1,595	\$1,600	\$1,637	\$1,696	\$1,471		50-54	\$1,817	\$1,595	\$1,600	\$1,637	\$1,696	\$1,471
	55-59	\$2,100	\$1,788	\$1,788	\$1,876	\$1,927	\$1,646		55-59	\$2,100	\$1,788	\$1,788	\$1,876	\$1,927	\$1,646
	60-64	\$2,261	\$1,933	\$1,918	\$1,980	\$2,052	\$1,754		60-64	\$2,261	\$1,933	\$1,918	\$1,980	\$2,052	\$1,754

Notes:

For Subscriber & Spouse and Family, rates are based on the age of the younger spouse.
 For more information, call your agent or Blue Cross of California at 800-333-0912.

Age Range		HIPAA PPO Share 5000 (R417)					
		Area 1	Area 2	Area 3	Area 4	Area 5	Area 6
Single	<15	\$223	\$207	\$206	\$221	\$219	\$200
	15-29	\$296	\$281	\$279	\$283	\$284	\$260
	30-34	\$390	\$360	\$360	\$363	\$368	\$333
	35-39	\$433	\$396	\$391	\$403	\$411	\$371
	40-44	\$513	\$457	\$457	\$468	\$474	\$422
	45-49	\$580	\$514	\$512	\$529	\$535	\$471
	50-54	\$714	\$621	\$621	\$639	\$652	\$574
	55-59	\$869	\$746	\$740	\$774	\$790	\$689
60-64	\$928	\$799	\$807	\$816	\$818	\$707	
Subscriber & Spouse	15-29	\$760	\$685	\$677	\$690	\$706	\$622
	30-34	\$879	\$793	\$783	\$803	\$823	\$723
	35-39	\$971	\$870	\$859	\$880	\$909	\$800
	40-44	\$1,037	\$930	\$934	\$948	\$973	\$857
	45-49	\$1,156	\$1,022	\$1,027	\$1,052	\$1,083	\$938
	50-54	\$1,409	\$1,232	\$1,244	\$1,267	\$1,303	\$1,133
	55-59	\$1,675	\$1,447	\$1,446	\$1,501	\$1,543	\$1,344
	60-64	\$1,768	\$1,547	\$1,555	\$1,579	\$1,609	\$1,384
Subscriber & Child	15-29	\$760	\$685	\$677	\$690	\$706	\$622
	30-34	\$879	\$793	\$783	\$803	\$823	\$723
	35-39	\$971	\$870	\$859	\$880	\$909	\$800
	40-44	\$1,037	\$930	\$934	\$948	\$973	\$857
	45-49	\$1,156	\$1,022	\$1,027	\$1,052	\$1,083	\$938
	50-54	\$1,409	\$1,232	\$1,244	\$1,267	\$1,303	\$1,133
	55-59	\$1,675	\$1,447	\$1,446	\$1,501	\$1,543	\$1,344
	60-64	\$1,768	\$1,547	\$1,555	\$1,579	\$1,609	\$1,384
Family	15-29	\$1,088	\$1,012	\$1,005	\$1,070	\$1,088	\$992
	30-34	\$1,272	\$1,194	\$1,188	\$1,219	\$1,246	\$1,124
	35-39	\$1,356	\$1,253	\$1,251	\$1,279	\$1,327	\$1,180
	40-44	\$1,465	\$1,331	\$1,332	\$1,353	\$1,390	\$1,232
	45-49	\$1,571	\$1,397	\$1,395	\$1,447	\$1,489	\$1,293
	50-54	\$1,817	\$1,595	\$1,600	\$1,637	\$1,696	\$1,471
	55-59	\$2,100	\$1,788	\$1,788	\$1,876	\$1,927	\$1,646
	60-64	\$2,261	\$1,933	\$1,918	\$1,980	\$2,052	\$1,754
Subscriber & Children	15-29	\$1,088	\$1,012	\$1,005	\$1,070	\$1,088	\$992
	30-34	\$1,272	\$1,194	\$1,188	\$1,219	\$1,246	\$1,124
	35-39	\$1,356	\$1,253	\$1,251	\$1,279	\$1,327	\$1,180
	40-44	\$1,465	\$1,331	\$1,332	\$1,353	\$1,390	\$1,232
	45-49	\$1,571	\$1,397	\$1,395	\$1,447	\$1,489	\$1,293
	50-54	\$1,817	\$1,595	\$1,600	\$1,637	\$1,696	\$1,471
	55-59	\$2,100	\$1,788	\$1,788	\$1,876	\$1,927	\$1,646
	60-64	\$2,261	\$1,933	\$1,918	\$1,980	\$2,052	\$1,754

Age Range		HIPAA Basic PPO 1000 (PE02)					
		Area 1	Area 2	Area 3	Area 4	Area 5	Area 6
Single	<15	\$223	\$207	\$206	\$221	\$219	\$200
	15-29	\$296	\$281	\$279	\$283	\$284	\$260
	30-34	\$390	\$360	\$360	\$363	\$368	\$333
	35-39	\$433	\$396	\$391	\$403	\$411	\$371
	40-44	\$513	\$457	\$457	\$468	\$474	\$422
	45-49	\$580	\$514	\$512	\$529	\$535	\$471
	50-54	\$714	\$621	\$621	\$639	\$652	\$574
	55-59	\$869	\$746	\$740	\$774	\$790	\$689
60-64	\$928	\$799	\$807	\$816	\$818	\$707	
Subscriber & Spouse	15-29	\$760	\$685	\$677	\$690	\$706	\$622
	30-34	\$879	\$793	\$783	\$803	\$823	\$723
	35-39	\$971	\$870	\$859	\$880	\$909	\$800
	40-44	\$1,037	\$930	\$934	\$948	\$973	\$857
	45-49	\$1,156	\$1,022	\$1,027	\$1,052	\$1,083	\$938
	50-54	\$1,409	\$1,232	\$1,244	\$1,267	\$1,303	\$1,133
	55-59	\$1,675	\$1,447	\$1,446	\$1,501	\$1,543	\$1,344
	60-64	\$1,768	\$1,547	\$1,555	\$1,579	\$1,609	\$1,384
Subscriber & Child	15-29	\$760	\$685	\$677	\$690	\$706	\$622
	30-34	\$879	\$793	\$783	\$803	\$823	\$723
	35-39	\$971	\$870	\$859	\$880	\$909	\$800
	40-44	\$1,037	\$930	\$934	\$948	\$973	\$857
	45-49	\$1,156	\$1,022	\$1,027	\$1,052	\$1,083	\$938
	50-54	\$1,409	\$1,232	\$1,244	\$1,267	\$1,303	\$1,133
	55-59	\$1,675	\$1,447	\$1,446	\$1,501	\$1,543	\$1,344
	60-64	\$1,768	\$1,547	\$1,555	\$1,579	\$1,609	\$1,384
Family	15-29	\$1,088	\$1,012	\$1,005	\$1,070	\$1,088	\$992
	30-34	\$1,272	\$1,194	\$1,188	\$1,219	\$1,246	\$1,124
	35-39	\$1,356	\$1,253	\$1,251	\$1,279	\$1,327	\$1,180
	40-44	\$1,465	\$1,331	\$1,332	\$1,353	\$1,390	\$1,232
	45-49	\$1,571	\$1,397	\$1,395	\$1,447	\$1,489	\$1,293
	50-54	\$1,817	\$1,595	\$1,600	\$1,637	\$1,696	\$1,471
	55-59	\$2,100	\$1,788	\$1,788	\$1,876	\$1,927	\$1,646
	60-64	\$2,261	\$1,933	\$1,918	\$1,980	\$2,052	\$1,754
Subscriber & Children	15-29	\$1,088	\$1,012	\$1,005	\$1,070	\$1,088	\$992
	30-34	\$1,272	\$1,194	\$1,188	\$1,219	\$1,246	\$1,124
	35-39	\$1,356	\$1,253	\$1,251	\$1,279	\$1,327	\$1,180
	40-44	\$1,465	\$1,331	\$1,332	\$1,353	\$1,390	\$1,232
	45-49	\$1,571	\$1,397	\$1,395	\$1,447	\$1,489	\$1,293
	50-54	\$1,817	\$1,595	\$1,600	\$1,637	\$1,696	\$1,471
	55-59	\$2,100	\$1,788	\$1,788	\$1,876	\$1,927	\$1,646
	60-64	\$2,261	\$1,933	\$1,918	\$1,980	\$2,052	\$1,754

The HIPAA PPO Share 5000 and HIPAA Basic PPO 1000 are offered by BC Life & Health Insurance Company.

Notes:
 For Subscriber & Spouse and Family, rates are based on the age of the younger spouse.
 For more information, call your agent or Blue Cross of California at 800-333-0912.



BlueCross
of California



BC Life & Health
Insurance Company

The HIPAA PPO Share 2500 and HIPAA PPO Share 1500 Plans are offered by Blue Cross of California. The HIPAA Basic PPO 1000 and the HIPAA PPO 5000 Plans are offered by BC Life & Health Insurance Company.

Blue Cross of California and BC Life & Health Insurance Company are Independent Licensees of the Blue Cross Association (BCA). The Blue Cross name and symbol are registered service marks of the BCA.

*Blue Cross of California
2000 Corporate Center Drive
Newbury Park, California 91320
www.bluecrossca.com*

*3962 12/06
Rates effective 1/1/07*



Enrollment Form for Coverage under HIPAA

(Health Insurance Portability and Accountability Act)

HIPAA PPO Share 2500 and HIPAA PPO Share 1500 are offered by Blue Cross of California. BC Life HIPAA Basic PPO 1000 and BC Life HIPAA PPO Share 5000 are offered by BC Life & Health Insurance Company.



1. Enrollee Information

Please print in blue or black ink.

2. Choice of Blue Cross Individual Coverage

Enrollee's Last Name	First Name	M.I.
Home Address (Must be complete: P.O. Box not acceptable)		
City	State	ZIP Code

Choose one plan per enrollment form.

- BC Life HIPAA Basic PPO 1000 (PE02)
- BC Life HIPAA PPO Share 5000 (R417)
- HIPAA PPO Share 2500 (R415)
- HIPAA PPO Share 1500 (R416)

Billing Address (If different than above.) or P.O. Box	Personal Mail Box (PMB) No.	Daytime Phone No. () ()	Fax Phone No. () ()
City / State / ZIP Code	County (Required)	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	Applicant/Spouse Maiden Name
E-mail Address	If possible, do you want e-mail notification? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has any person listed on this application resided outside the U.S. for the past three (3) consecutive months? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Language Choice (Optional) <input type="checkbox"/> English <input type="checkbox"/> Korean <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese			

3. Family Members Enrolling

Please list ALL eligible family members enrolling.

If a listed family member's last name is different from your own, please explain on a separate sheet of paper.

Relation	Last Name	First Name	M.I.	Social Security or ID No.	Date of Birth	Age
10 <input type="checkbox"/> Male 20 <input type="checkbox"/> Female	Yourself					
30 <input type="checkbox"/> Male 40 <input type="checkbox"/> Female	Spouse*					
<input type="checkbox"/> Son <input type="checkbox"/> Daughter						
<input type="checkbox"/> Son <input type="checkbox"/> Daughter						
<input type="checkbox"/> Son <input type="checkbox"/> Daughter						
<input type="checkbox"/> Son <input type="checkbox"/> Daughter						

Dependent Information: Do you claim any child listed above who is between the ages of 19 through 22 as a dependent on your Federal Income Tax? Yes No
 If "No", any child between the ages of 19 through 22 who is not claimed on your Federal Income Tax is NOT eligible as a dependent but may apply individually.
 *Spouse includes domestic partner (when applicable).

- Have all enrollees had a minimum of 18 months of continuous health coverage most recently under an employer-sponsored group health plan that ended within the last 63 days for a reason other than fraud or non-payment of premium? Yes No
If yes, please attach the Certificate of Creditable Coverage provided by your former employer or carrier OR letter from the employer giving us the start and end date of coverage.
 Name of insurance carrier: _____ Phone No. () _____
If no for any enrollee, then he or she is not eligible for this guarantee issue plan.
- Were all enrollees eligible for COBRA or Cal-COBRA? Yes No
If yes, date coverage started (Mo/Day/Yr) _____ Date coverage ended (Mo/Day/Yr) _____
If no, please explain: _____
 If all available COBRA or Cal-COBRA is not exhausted for any enrollee, then he or she is not eligible for this coverage.
- Is any enrollee currently covered by or eligible for Medicaid, Medicare or any other employer-sponsored health insurance benefits or does any enrollee have other health coverage? Yes No
If yes for any enrollee, then he or she is not eligible for this coverage.



4. Conditions of Enrollment – IMPORTANT: It is important that you carefully read and fully understand the following:

Effective Date

- I request that Blue Cross assign an effective date if this enrollment form is processed. The effective date will be assigned as either the 1st or the 15th of the month following the approval date of this enrollment form.
- If Blue Cross processes this enrollment form, please assign an effective date of _____.

Requested effective date must be within 63 days of prior coverage termination date. Blue Cross will allow a retroactive effective date to coincide with the prior coverage termination date.

For HIPAA enrollees, coverage is based upon section 1399.805(b) and payment of premium.

Please allow a minimum of 30 days from the date of this enrollment form for processing.

REQUESTING AN EFFECTIVE DATE DOES NOT GUARANTEE PROCESSING TO BE COMPLETED BEFORE THE DATE REQUESTED.

Agreement

By requesting coverage, I, the undersigned, agree to the following:

1. Blue Cross may decline my enrollment form if I do not qualify, and if so, I will not have any coverage. No coverage comes into effect unless and until Blue Cross processes this enrollment form and notifies me in writing.
2. Even if I pay money with this enrollment form, that money is only a deposit against future premium if this enrollment form is accepted. Cashing my check does not mean my enrollment

form is processed. If this enrollment form is declined, neither Blue Cross nor any affiliated company shall have any liability to me, except for the obligation to return the money submitted with this enrollment form. If this enrollment form is not accepted, I will not be entitled to benefits or coverage from Blue Cross.

3. The selling agent has no authority to promise me coverage or to modify Blue Cross underwriting policy or the terms of any Blue Cross coverage.

Requirements for Binding Arbitration

If you are applying for coverage, please note that Blue Cross requires binding arbitration to settle all disputes against Blue Cross, including claims of medical malpractice. California Health and Safety Code Section 1363.1 and Insurance Code Section 10123.19 require specified disclosures in this regard, including the following notice: **“It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.”** Both parties also agree to give up any right to pursue on a class basis any claim or controversy against the other.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL
Signatures (Required) – IMPORTANT: All applicants over age 18 must sign and date.

Enrollee / Parent or Legal Guardian X	Today's Date	Enrollee's Spouse X	Today's Date
Enrollee age 18 or over X	Today's Date	Enrollee age 18 or over X	Today's Date

HIV TESTING PROHIBITED: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.

■ **IMPORTANT: All signatures MUST include today's date** ■



ATTACH BLANK, VOIDED CHECK FOR BANK DRAFT AUTHORIZATION,
IF APPLICABLE, HERE. DO NOT TAPE.

Applicant's Social Security or ID No.

5. Payment Method Premium payment required. First payment will be credited to approved applicants only. By sending your check to us, you authorize Blue Cross of California to convert your check into an electronic fund transfer. If you are approved for coverage, your bank account will be debited for the amount indicated on the check. If you do not qualify for coverage, your check will not be submitted for a funds transfer. Please be aware that your check will not be returned to you.

5A. Credit Card

Fax to: (800) 327-9255

- Initial premium (For new member's Medical and Dental fees only)
- Monthly premiums

Monthly Credit Card Authorization - As a convenience to me, I request and authorize you to charge my card for monthly recurring premiums approximately 10 days prior to each due date. I understand that the amount may vary as a result of changes I make, such as, but not limited to, adding and deleting dependents, or moving to a new location. The amount may also change as outlined in my policy. This authority is to remain in effect until revoked by me by providing you a 30-day written notice. I agree that you shall be fully protected in honoring any such card payments. I further agree that if any such card payment be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever, including any fees imposed by my bank, should my card be rejected even though such dishonor results in forfeiture of coverage.

Credit Card: VISA MasterCard Discover

Card No.: _____ Exp. Date: _____

Cardholder's Name PRINT (As it appears on the credit card)	Date	Authorized Signature (As it appears on the credit card)	Date
X		X	

5B. Checking Account Automatic Premium Payment

- Monthly checking account deduction premium payments

Name of Bank or Financial Institution:

Account No.: _____ Bank Routing No.: _____

Submit a blank check marked "VOID" above where indicated (DEPOSIT SLIPS NOT ACCEPTABLE). If your application is approved, the premium for all products selected, including dental and/or life, will be deducted from your checking account. Premiums may be prorated in order to adjust the initial paid to date or in the event of membership changes.

Monthly Checking Account Automatic Premium Payment Authorization - As a convenience to me, I request and authorize you to pay and charge to my account checks drawn on that account by and payable to the order of BLUE CROSS OF CALIFORNIA provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such debit shall be the same as if it were a check signed personally by me. I authorize Blue Cross of California to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Blue Cross of California premiums. This authority is to remain in effect until revoked by me by providing you a 30-day written notice. I agree that you shall be fully protected in honoring any such debit. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance. NOTE: Should your withdrawal not be honored by your bank, you will automatically be removed from Monthly Checking Account Automatic Premium Payment and be billed bi-monthly. You will incur a \$25 service charge for any withdrawal not honored.

Cardholder's Name PRINT (As it appears in the financial institution's records)	Date
X	

5C. Billing (To be used if an automatic payment option is NOT selected from 5A or 5B above.)

- Bi-monthly (Submit 2 months premium)
- Quarterly (Submit 3 months premium)



6. Statement of Accountability – Complete when the enrollee cannot fill out the enrollment form for coverage under HIPAA.

I, _____, personally read and completed this enrollment form for the enrollee named below because:

- Enrollee does not read English Enrollee does not speak English Enrollee does not write English
 Other (explain): _____

I translated the contents of this form and to the best of my knowledge obtained and listed all the requested personal and medical history disclosed by: _____

I also translated and fully explained the "Conditions of Enrollment."

Signature of Translator (Required) X	Date
--	------

7. To the Blue Cross-Appointed Agent or Representative

1. **Your client must personally read and complete this enrollment form. If your client does not read or write English, the Statement of Accountability must be completed.**
2. Did you see the proposed subscriber at the time this enrollment form was executed? Yes No
 If no, please explain: _____

Name of Agent (Print name)	Agent's Street Address	Suite No.
Agent I.D. No.	City / State / ZIP Code	
Phone No. ()	Fax No. ()	Signature of Agent (Required) X
		Date (Required)

Mail Service Agreement to: Broker/Agent Subscriber

PLEASE NOTE: If neither box is checked, the Service Agreement will be mailed directly to the subscriber.

Mailing Address

Enrollee:

Please return this enrollment form to the agent.

Agent:

Please mail to:
 Blue Cross of California
 P.O. Box 9041
 Oxnard, CA 93031-9041



DO NOT WRITE IN THIS AREA

Blue Cross of California and BC Life & Health Insurance Company are Independent Licensees of the Blue Cross Association (BCA). The Blue Cross name and symbol are registered service marks of the BCA.





Why another questionnaire?

This questionnaire asks you to provide information about your health. This is completely voluntary and your responses are strictly confidential and will not impact your health coverage. This information will help us recommend Blue Cross programs designed to help you improve your health.

1. In general, my health is:

- Excellent Very Good Good Fair Poor

2. My current height and weight. _____ ' - _____ " Height (feet'/inches") _____ Weight (pounds)

3. I have been told by my health care provider that I have the following health conditions.

Please check only the responses that apply to you.

Yes, diagnosed within a year

Yes, diagnosed more than a year ago

- | | | |
|---|--------------------------|--------------------------|
| <input type="checkbox"/> Hypertension (High Blood Pressure) [HTN] | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Coronary Artery Disease (Heart Disease) [CAD] | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Kidney Disease [KD] | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Congestive Heart Failure [CHF] | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Asthma or Chronic Obstructive Pulmonary Disease [COPD] | <input type="checkbox"/> | <input type="checkbox"/> |

4. I visit my doctor regularly for any health conditions I may have

- Yes No

Physician's name: _____

Physician phone number: _____

5. I have instructions from my health care provider and know when to call my doctor if my health is worsening.

- Yes No

6. I take medication as prescribed.

- Always Sometimes Never

7. Right now I am confident that I can follow all my doctor's instructions

- I am very confident I am somewhat confident I am not confident

8. I am:

- Not a smoker A current smoker A former smoker

9. I would like assistance with the following:

- Quitting smoking
- Following a healthy diet
- Beginning an exercise plan (or modifying an existing one) to help me reach my goals
- Building a support system to help manage my health
- Working better together with my health care provider/physician
- None of the above

10. Having a chronic condition can be very taxing. As part of our care management programs, we want to help you identify possible signs of depression. Please remember that only your doctor can diagnose depression, and this questionnaire may help you to seek advice from your physician and may help us identify additional resources Blue Cross can offer you.

- Over the past two weeks, I have found myself crying often and/or feeling down or hopeless.
- I have felt little interest or pleasure doing things I usually enjoy.

Blue Cross offers MedCall, a 24-hour program available toll free at (800) 977-0027. When you need medical resources or are unsure whether to call your doctor, nurses on this 24-hour hotline will talk to you about your condition.

In order to work with you in managing your health, please complete all of the information below.

Name _____ SSN _____
Address _____ Phone _____
_____ Email _____

I am currently enrolled in a Blue Cross plan.

- Yes No

I am currently enrolled in Case Management or a Health Improvement Plan.

- Yes No

Please choose your preferred contact method:

- Email Phone Mail

Thank you for your time. We look forward to serving you better with your health needs.

Please remit your completed questionnaire to:

Blue Cross of California
P.O. Box 9041
Oxnard, CA 93031-9041

All information you provide will remain confidential.

Blue Cross of California and BC Life & Health Insurance Company are Independent Licensees of the Blue Cross Association (BCA). The Blue Cross name and symbol are registered service marks of the BCA.