



Consumer-Driven Health Plans for Small Groups

Lumenos HSA 1500*

Effective May 1, 2007

* Health Savings Account Compatible Plan

Lumenos Consumer-Driven Health Plans

Offered by BC Life & Health Insurance Company

Summary of Benefits

You don't need to tell us that health care is getting less affordable every day. So many factors contribute to the escalation in costs.

BC Life & Health Insurance Company (Blue Cross), an affiliate of Blue Cross of California, has been around for a long time. And as a leader in the industry, we believe quality care ultimately leads to lower health care costs and a healthier health care system.

Our consumer driven health plans manage costs by giving consumers more control over their health care dollars. Our family of Lumenos plans is designed to:

- Empower employees to be more informed about their health and health care options.
- Help employees save money for future health expenses
- Give your employees incentives and the support they need to make healthy lifestyle changes

Whether you're ready for a full consumer-driven health benefits program right now, or wish to offer your employees another option, we have a Lumenos plan for you:

Blue Cross Lumenos Health Savings Account (HSA-Compatible) Plan

The Lumenos HSA offers maximum cost effectiveness for a benefits plan. It provides consumers with a Health Savings Account, or HSA, which they can use to pay for their medical care expenses and prescriptions. The HSA is funded by the employees' pre-tax contributions; however employers also have the option of making contributions to their employees' HSA accounts. Another unique feature of this Lumenos plan is that the HSA account is portable and is entirely owned by the consumer.

Blue Cross has partnered with Mellon Trust of New England to administer and support Lumenos HSA accounts. The features and services included with the Mellon HSA were designed to meet all of the HSA account holder's needs. This includes:

- A single point of contact for health plan and HSA customer service
- Single online health site to access benefits and HSA details
- Competitive interest rates and investment options for an HSA account

The Lumenos HSA also includes a Traditional Health Coverage (PPO) component, similar to a typical health plan, to help protect consumers against large health expenses.

SMALL GROUP Lumenos HSA 1500 (HSA-Compatible) Plan

All amounts listed are the member's responsibility, unless otherwise noted. In-network negotiated fees can result in 30 to 40 percent savings compared to a provider's usual fees. This is an overview of coverage only. Please refer to the certificate for a comprehensive description of this plan's benefits, limitations and exclusions.

| Core Features | In-network Receive Negotiated Savings | Out-of-network Pay Higher Costs |
|--|--|--|
| Annual Deductible Medical/pharmacy combined; Applies toward the Annual Out-of-Pocket Maximum | Single member: \$1,500 Family: \$3,000 aggregate ¹ | |
| Maximum Lifetime Covered Charges Paid by Blue Cross | \$5,000,000 | |
| Annual Out-of-Pocket Maximum Medical/pharmacy combined (certain member payments do not apply ²) | Single member: \$1,500 Family: \$3,000 aggregate ¹ | Single member: \$3,000 Family: \$6,000 aggregate ¹ |
| Office Visits | 0% after annual deductible (Preventive care includes nationally recommended preventive services, not subject to deductible) | 30% plus 100% of excess charges after annual deductible |
| Other Professional Services Includes maternity, diagnostic lab and x-ray | 0% after annual deductible | 30% plus 100% of excess charges after annual deductible |
| Hospital Inpatient Facility Services Preservice Review required | 0% after annual deductible | All charges in excess of \$650 per day after annual deductible |
| Hospital Inpatient Professional Services (lab, physician, anesthesia) | 0% after annual deductible | 30% plus 100% of excess charges after annual deductible |
| Outpatient Facility Services Preservice Review required for certain services and procedures | 0% after annual deductible | All charges in excess of \$380 per day after annual deductible |
| Ambulatory Surgical Centers Preservice Review required | 0% after annual deductible | All charges in excess of \$380 per day after annual deductible |
| Prescription Drugs³ Member payments apply to combined medical/pharmacy annual deductible (30-day supply for retail; 90-day supply for mail-order) | 0% after annual deductible | 30% of drug limited fee schedule plus 100% of excess charges after annual deductible |
| Annual Preventive Care (each family member, regardless of age - not subject to deductible) | 0% (includes nationally recommended preventive services) | 30% of negotiated fee plus 100% of excess charges after annual deductible |
| HealthyCheck[®] Centers: (includes certain lab tests, immunizations and health education information) | Not applicable (covered under preventive care benefit) | Not applicable (covered under preventive care benefit) |

¹Per family amount is aggregate, i.e., when one or more family member's eligible covered expenses (combined) meet this amount, the requirement is satisfied for all covered family members

²Services that do not apply to the annual out-of-pocket maximum include, but are not limited to: amounts paid for acupuncture/acupressure when services are performed by an out-of-network provider; amounts paid for mental or nervous disorders and substance abuse (except for treatment of severe mental illness and serious emotional disturbances of a child) when performed by an out-of-network provider; and non-covered services.

³Infertility Drugs: Infertility drug lifetime maximum Blue Cross payment \$1,500 in-network and out-of-network combined.

| Additional Features | In-network Receive Negotiated Savings | Out-of-network Pay Higher Costs |
|---|---|---|
| Well Baby immunizations and Adult Screening Tests (deductible waived for preventive services) Children through age 6: regular check-ups and immunizations Adults 7-Adult: includes annual Pap, breast exam and mammogram for women and Prostate Specific study for men | Covered under preventive care benefit | Covered under preventive care benefit |
| Emergency Care | 0% after annual deductible | 0% 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 | 0% after annual deductible | 0% of customary and reasonable charges plus 100% of excess charges after annual deductible |
| Skilled Nursing Facility 100 days per year, in-network and out-of-network combined; Pre-service Review required | 0% after annual deductible | All charges in excess of \$150 per day after annual deductible |
| Home Health Care 100 visits per year, up to four hours each visit; in-network and out-of-network combined; Pre-service Review required | 0% 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 | 0% 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; Pre-service 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 Pre-service Review required | 0% after annual deductible | After annual deductible: <ul style="list-style-type: none"> · 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 |
| Infertility Services³ Maximum lifetime Blue Cross payment \$2,000, in-network and out-of-network combined | 0% after annual deductible | 30% plus 100% of excess charges after annual deductible |

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

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²Services that do not apply to the annual out-of-pocket maximum include, but are not limited to: amounts paid for acupuncture/acupressure when services are performed by an out-of-network provider; amounts paid for mental or nervous disorders and substance abuse (except for treatment of severe mental illness and serious emotional disturbances of a child) when performed by an out-of-network provider; and non-covered services.

³Infertility Drugs: Infertility drug lifetime maximum Blue Cross payment \$1,500 in-network and out-of-network combined.

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 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 and all disputes between the employer and/or the member and Blue Cross, including but not limited to claims of medical malpractice, must be resolved by binding arbitration (not by lawsuit or trial by court or jury or other court process, except as California's 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 by a court or jury trial.

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 2006 was 80.5 percent. This ratio was calculated after provider discounts were applied.



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