

SIMPLE & **CONSISTENT**

Small Group EmployeeElect
Classic HMO Plan



BlueCross
of California



Solutions

Small Business Health Care Plans

at **Work**

Blue Cross ... *coverage you can trust.*

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

Classic HMO ... an ideal balance of benefits and value.

It's all about you.

- You get unlimited in-network covered benefits over your lifetime, while the coverage is in force
- You pay low premiums, predictable out-of-pocket costs and no annual deductible
- You choose your medical group and primary care physician from our vast network
- You get the convenience of no claims or paperwork

Comprehensive **Coverage**

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 offered by independent vendors and practitioners
- **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** powered by WebMD provides a wealth of personalized information to assist with understanding and managing health issues, making responsible health care decisions and reaching your health care goals

Predictable **Costs.**

It's Easy to use your plan.

Your Blue Cross HMO plan coordinates health care services with you, a Participating Medical Group (PMG) or Independent Practice Association (IPA), and a Primary Care Physician.

Choosing a Doctor

When enrolling in this plan, you choose a doctor for yourself (and for each enrolled family member) from a PMG or IPA in our network. The doctor you choose is called your Primary Care Physician, and this doctor is responsible for managing your health care needs. Generally, Primary Care Physicians specialize in internal medicine, general practice, family practice or pediatrics.

Getting Medical Care

You simply call your Primary Care Physician when you need medical care. Also, women may go to an OB/GYN in our network without a referral. To receive plan benefits for care provided by other specialists, you will need a referral from your PMG or IPA before you receive the service. This includes hospitalization, except in emergencies.

In an Emergency

If you need emergency care, **call 911** or go to the nearest emergency room. If, as a result of the emergency condition, you are admitted to the hospital, you or a member of your family must notify your Primary Care Physician within 48 hours.

Blue Cross SpeedyReferralSM & Blue Cross DirectAccess Programs

Many medical groups participate in these two programs. The Blue Cross SpeedyReferral program makes the referral process faster and easier. The Blue Cross DirectAccess program allows you to self-refer to participating specialists in allergy, dermatology, and ear/nose/throat health conditions. Confirm your PMG's or IPA's participation in the program before contacting the specialists directly.

The Classic HMO Plan.

SMALL GROUP Classic HMO Plan

All amounts listed are the member's responsibility to pay after deductibles, unless otherwise noted.

CORE FEATURES	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible	None	None
Lifetime Covered Charges Paid by Blue Cross	Unlimited (in-network only, unless medical emergency)	Not applicable
Annual Out-of-Pocket Maximum¹ 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	\$1,750 per member \$3,500 per family (one or more members—aggregate) Certain member payments do not apply	Not applicable
Office Visits Includes office visits for maternity	\$20 copay	Not covered
Other Professional Services Includes maternity, diagnostic lab and X-ray	No charge	Not covered
Hospital Inpatient Facility Services Preservice Review required	\$250 copay per admission	Not covered, except for emergency services
Hospital Inpatient Professional Services (lab, physician, anesthesia)	No charge	Not covered, except for emergency services
Outpatient Facility Services Preservice Review required for certain services and procedures	20% of negotiated fee	Not covered, except for emergency services
Ambulatory Surgical Centers and Dialysis Centers Preservice Review required	20% copay	Not covered, except for emergency services
Prescription Drugs² 30-day supply retail; up to a 60-day supply available through mail order	<u>Generic:</u> \$10 copay <u>Brand-name if generic not available:</u> \$25 copay after \$150 brand-name prescription drug deductible <u>Brand-name if generic is available:</u> \$10 copay plus the difference in cost between brand-name drug and generic equivalent after \$150 brand-name prescription drug deductible <u>Self-injectable (except insulin):</u> 30% of negotiated fee (subject to brand-name prescription drug deductible, if applicable)	50% of drug limited fee schedule plus 100% of excess charges if filled within California after annual \$150 brand-name prescription drug deductible per member, in-network and out-of-network combined Mail order not available

¹ Services that do not apply to the annual out-of-pocket maximum include, but are not limited to: copay paid or the brand-name prescription drug deductible applied under the pharmacy benefit; infertility copay; copay for not obtaining preservice review; non-covered services.

² 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 drug is available, even if the physician writes a "dispense as written" or "do not substitute" prescription, the member will be responsible for the generic copay plus the difference in cost between the brand-name drug and the generic equivalent drug. The amount paid does not apply to the member's brand-name deductible.

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

ADDITIONAL FEATURES	IN-NETWORK	OUT-OF-NETWORK
Well Baby Immunizations and Adult Screening Tests	\$20 copay per office visit	Not covered
Emergency Care • Professional Services • Outpatient Hospital Services	No charge \$100 emergency room copay – waived if admitted	No charge \$100 emergency room copay – waived if admitted
Ambulance	No charge if ordered by the Primary Care Physician or in an emergency	Not covered, except for medical emergency services or authorized referral
Skilled Nursing Facility 100 days per year in a two-bed room Preservice Review required	No charge	Not covered
Home Health Care Up to 3 two-hour visits per day, Preservice Review required	No charge if ordered by the Primary Care Physician	Not covered
Physical/Occupational Therapy Up to 60 consecutive days following an illness or injury	No charge if ordered by the Primary Care Physician	Not covered
Chemical Dependency/Inpatient* Detoxification for alcohol or drug abuse (acute stage only)	\$250 copay per admission for inpatient services	Not covered
Mental Health/Outpatient Professional Services* One visit per day, 20 visits per year	\$20 copay	Not covered
Infusion Therapy/Chemotherapy Preservice Review required • Professional Services • Facility Fees	No charge 20% copay	Not covered Not covered
Infertility Services Limited to services related to testing	50% copay	Not covered

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

Exclusions and Limitations

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

- Any amounts in excess of maximums stated in the Combined Evidence of Coverage and Disclosure Form.
- Services or supplies that are not medically necessary.
- Services received before your effective date.
- Services received after your coverage ends.
- Any conditions for which benefits can be recovered under any workers' compensation, employers' liability law or occupational disease law.
- Services you receive for which you are not legally obligated to pay.
- Services for which no charge is made to you in the absence of insurance coverage.
- Services not listed as covered in the Combined Evidence of Coverage and Disclosure Form.
- Services from relatives.
- Vision care except as specifically stated in the Combined Evidence of Coverage and Disclosure Form.
- Eye surgery performed solely for the purpose of correcting refractive defects.
- Hearing aids.
- Sex changes.
- Dental and orthodontic services except as specifically stated in the Combined Evidence of Coverage and Disclosure Form.
- Cosmetic surgery.
- Routine physical examinations except as specifically stated in the Combined Evidence of Coverage and Disclosure Form.
- Treatment of mental or nervous disorders (including nicotine use) or psychological testing, except as specifically stated in the Combined Evidence of Coverage and Disclosure Form.
- Custodial care.
- Experimental or investigational services.
- Services provided by a local, state or federal government agency, unless you have to pay for them.
- Diagnostic admissions.
- Telephone or facsimile machine consultations.
- Personal comfort items.
- 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 in connection with a surrogate pregnancy.
- Immunizations for travel outside the United States.
- Educational services except as specifically stated in the Combined Evidence of Coverage and Disclosure Form.
- Infertility services (including sterilization reversal) except as specifically stated in the Combined Evidence of Coverage and Disclosure Form.
- Care provided in a non-contracting hospital.
- Private duty nursing.

- 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.
- Care not authorized by your PMG or IPA.
- Amounts in excess of customary and reasonable charges for care rendered by a non-participating provider without a referral from your PMG or IPA.
- Rehabilitative care, such as physical therapy, occupational therapy and speech therapy, except as specifically stated in the Combined Evidence of Coverage and Disclosure Form.
- Conditions of the jaw or teeth secondary to malocclusion or orthognathic conditions.
- Growth hormone treatment.
- Acupuncture/acupressure.
- Durable Medical Equipment except as specifically stated in the Combined Evidence of Coverage and Disclosure Form.

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

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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 Managed Health Care

The California Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (800) 627-8797 and use your health plan's grievance process before contacting the DMHC. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the DMHC for assistance. Your case may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency or urgent medical services. The DMHC also has a toll-free telephone number (888-HMO-2219), and TDD line (877-688-9891) for the hearing- and speech-impaired. The department's Internet Web site, www.hmohelp.ca.gov, has complaint forms, IMR application forms and instructions online.

Binding Arbitration

If the plan is subject to ERISA, any dispute involving an adverse benefit decision must be resolved under ERISA claims procedure rules, and is not subject to mandatory binding arbitration. Members may pursue voluntary binding arbitration after they have completed an appeal under ERISA rules. If the member has another dispute that does not involve an adverse benefit decision, or if the group does not provide a plan that is subject to ERISA, the following provisions apply: Any dispute between the employer and/or the member and Blue Cross must be resolved by binding arbitration (not by lawsuit or trial by jury or other court process, except as California law provides for judicial review of arbitration proceedings), if the amount in dispute exceeds the jurisdictional limit of the Small Claims Court. Under this coverage, both the member and Blue Cross

are giving up the right to participate in class arbitration or have any dispute decided in a court of law before a jury.

Medicare

Under TEFRA/DEFRA, Medicare is the primary coverage for groups of less than 20 employees. Blue Cross coverage is considered primary coverage for groups of 20 or more employees. This Blue Cross coverage is not a supplement to Medicare, but provides benefits according to the non-duplication of Medicare clause.

If Medicare is a member's primary health plan, Blue Cross will not provide benefits that duplicate any benefits you are entitled to receive under Medicare. This means that when Medicare is the primary health coverage, benefits are provided in accordance with the benefits of the plan, less any amount paid by Medicare. If you are entitled to Part A, B, C or D of Medicare, you will be eligible for non-duplicate Medicare coverage, with supplemental coordination of benefits. However, if you are required to pay the Social Security Administration an additional premium for any part of Medicare, then the above policy will only apply if you are enrolled in that part of Medicare. Note: Medicare-eligible employees/dependents enrolled in plans where Medicare is primary may obtain an Individual Blue Cross of California Medicare Supplement plan with the pre-existing condition exclusion waived.

Coordination of Benefits

The benefits of a member's plan may be reduced if the member has other group health, dental, drug or vision coverage, so that benefits and services the member receives from all group coverages do not exceed 100 percent of the covered expense.

Third-Party Liability

If a member is injured, the responsible party may be legally obligated to pay for medical expenses related to that injury. Blue Cross may recover benefits paid for medical expenses if the member recovers damages from a legally liable third-party. Examples of third-party liability situations include car accidents and work-related injuries.

Voiding Coverage for False and Misleading Information

False or misleading information or failure to submit any required enrollment materials may form the basis for voiding coverage from the date a plan was issued or retroactively adjusting the premium to what it would have been if the correct information had been furnished. No benefits will be paid for any claim submitted if coverage is made void. Premiums already paid for the time period for which coverage was rescinded will be refunded, minus any claims paid.

Incurred Medical Care Ratio

As required by law, we are advising you that Blue Cross of California and its affiliated companies' incurred medical care ratio for 2005 was 80.87 percent. This ratio was calculated after provider discounts were applied.

10 Things You Should Know About Generic Drugs

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



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



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

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