



BC Life & Health  
Insurance Company

*Small Group Employee Elect*

# **Power HealthFund 750 Plan**

A background image showing a hand holding a pen over a document with charts and glasses. The image is faded and serves as a backdrop for the text.

**Solutions**  
Small Business Health Care Plans **at Work**

## With the Power HealthFund 750 Plan, you're in charge.

### Power HealthFund = First Dollar Coverage

The Power HealthFund 750 Plan from BC Life & Health Insurance Company gives you more power over your health care and financial decisions. This plan offers "first dollar coverage" which helps "fund" your medical expenses before your Annual Deductible is met – and much more. Featuring easy-to-understand, predictable benefits and costs, you can see the outstanding value simply by counting to 4:

#### 1. First Dollar Coverage (FDC): We pay \$750

We pay 100% of covered expenses (except prescription drugs) up to \$750 per individual and \$1,500 per family before you pay anything.

- For many, the First Dollar Coverage **covers an entire year** of health care costs
- We even **cover non-routine services** and hospital stays under our First Dollar Coverage
- **Unused amounts roll over** for one year\*



#### 2. Annual Deductible: Then you pay \$500

Then **you pay 100%** of all charges for covered services until eligible expenses reach the \$500 **Annual Deductible. The Annual Deductible is applied to the Annual Out-of-Pocket Maximum.**

#### 3. Copays & Coinsurance: Then we share the costs

After the Annual Deductible is reached, **predictable copays (for office visits) and coinsurance** kick in, leaving you only a portion of the negotiated cost – we pay the rest. Copays and coinsurance **apply to the Annual Out-of-Pocket Maximum** (either \$5,000 per member or \$10,000 family aggregate).



#### 4. Annual Out-of-Pocket Maximum: You won't pay more than \$5,000 in one year\*\*

When the Annual Out-of-Pocket Maximum is met (and remember, the Annual Deductible and copays apply toward reaching it), **we pay 100%** for covered services for the rest of the year!

## For many, the First Dollar Coverage covers an entire year of health cost.

\*Unused amount does not over if enrolled in last quarter of the year.

\*\*For most covered services when you use participating providers.

# Powerful Savings from The Power of Blue<sup>SM</sup>

## This plan is easy to understand and easy on the budget.

With careful budgeting, your first dollar coverage can last a long time. In fact, depending on your needs, your first dollar coverage may cover all of your medical expenses for any given year! It is available for immediate use to pay for all covered medical expenses (except prescription drugs). And, because of valuable Blue Cross-negotiated savings, your first dollar coverage stretches even further when you use providers in our network.

## 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) In network you pay only a portion of the fees for your eligible covered expenses (see example) 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

EXPLANATION OF BENEFITS

Blue Cross Part: \$2,115.00  
It is your responsibility to pay: \$235.00  
It is not your responsibility to pay: \$2,840.80

THANK YOU FOR USING A NETWORK PARTICIPATING PROVIDER.

SERVICES (DATE(S))	TYPE OF SERVICE	TOTAL BILLED	AMOUNT NOT ALLOWED	PATIENT SAVINGS	APPLIED TO DEDUCTIBLE	COINSURANCE COVERAGE AMOUNT	MY COVERED AMOUNT
00100-2000-0000-0000	INPATIENT SERVICES	\$5,190.80	\$0.00	\$2,840.80	\$0.00	\$235.00	\$2,115.00
TOTAL THIS CLAIM		\$5,190.80	\$0.00	\$2,840.80	\$0.00	\$235.00	\$2,115.00

THIS IS NOT A BILL  
SEE REVERSE SIDE FOR IMPORTANT INFORMATION

*You're free to go to health care providers outside of the Blue Cross network, but you can 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<sup>SM</sup> to work for you.*

## And, your plan is packed with valuable programs and services ...

### Take advantage of these free resources:

- **HealthyExtensions<sup>SM</sup>** provides information about 10- 50% discounts on health and wellness products and services offered by independent vendors and practitioners
- **MedCall<sup>®</sup>** connects you to registered nurses 24 hours a day for answers to your medical questions
- **Baby Connection<sup>SM</sup>** 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

# 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
<b>First-Dollar Coverage</b> 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: <b>\$750</b> Family contract <sup>1</sup> : <b>\$1,500</b> aggregate	
<b>Annual Deductible</b> In-network and out-of-network combined; deductible accrues after first-dollar coverage is exhausted	Single member: <b>\$500</b> Family contract <sup>1</sup> : <b>\$1,000</b> aggregate	
<b>Maximum Lifetime Covered Charges Paid by Blue Cross</b> In-network and out-of-network combined	\$5,000,000	
<b>Annual Out-of-Pocket Maximum</b> 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: <b>\$5,000</b> Family contract <sup>1</sup> : <b>\$10,000</b> aggregate Certain member payments do not apply <sup>2</sup>	Once Blue Cross payments reach \$10,000 for a single member or \$20,000 aggregate for a family contract <sup>1</sup> , members pay nothing for covered expenses for the remainder of the year except charges over the allowed amounts <sup>2</sup>
<b>Office Visits</b> No maximum visits	<b>\$35</b> copay <sup>3</sup>	<b>50%</b> of negotiated fee <sup>3</sup> plus <b>100%</b> of excess charges
<b>Other Professional Services</b> Includes maternity, diagnostic lab and X-rays	<b>25%</b> of negotiated fee <sup>3</sup>	<b>50%</b> of negotiated fee <sup>3</sup> plus <b>100%</b> of excess charges
<b>Hospital Inpatient Facility Services</b> Preservice Review required	<b>25%</b> of negotiated fee <sup>3</sup>	All charges in excess of \$650 per day <sup>3</sup>
<b>Hospital Inpatient Professional Services</b> (lab, physician, anesthesia)	<b>25%</b> of negotiated fee <sup>3</sup>	<b>50%</b> of negotiated fee <sup>3</sup> plus <b>100%</b> of excess charges
<b>Outpatient Facility Services</b> Preservice Review required for certain services and procedures	<b>25%</b> of negotiated fee <sup>3</sup>	All charges in excess of \$380 per day <sup>3</sup>
<b>Ambulatory Surgical Centers</b> Preservice Review required	<b>25%</b> of negotiated fee <sup>3</sup>	All charges in excess of \$380 per day <sup>3</sup>
<b>Prescription Drugs<sup>4</sup></b> 30-day supply retail; up to a 60-day supply available through mail-order	Generic: <b>\$10</b> copay; brand-name if generic not available: <b>\$30</b> copay after annual <b>\$250</b> brand-name prescription drug deductible; brand-name if generic is available: \$10 copay after annual <b>\$250</b> brand-name prescription drug deductible <b>plus</b> the difference in cost between brand-name drug and generic equivalent; self-injectable (except insulin): <b>30%</b> of negotiated fee (subject to brand-name prescription drug deductible if applicable)	<b>50%</b> of drug limited fee schedule plus <b>100%</b> of excess charges if filled within California after annual <b>\$250</b> brand-name prescription drug deductible per member, in-network and out-of-network combined
<b>HealthyCheck<sup>SM</sup> Screenings, Ages 7-Adult</b> Includes certain lab tests, immunizations and health education information	<b>Not subject to annual deductible</b> <b>\$25</b> or <b>\$75</b> copay health screening options	Not available

<sup>1</sup> Family contract consists of two (2) or more enrolled members.

<sup>2</sup> 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.

<sup>3</sup> 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
<b>Well Baby Immunizations and Adult Screening Tests</b> <b>Children through age 6</b> Regular check-up and immunizations <b>Ages 7-Adult</b> Includes annual Pap, breast exam and mammogram for women and Prostate Specific Antigen (PSA) study for men	<b>\$35</b> copay for office visit; <b>25%</b> of negotiated fee for all other covered services <sup>3</sup>  Copayments do not apply to deductible	<b>50%</b> of negotiated fee <sup>3</sup> plus <b>100%</b> of excess charges
<b>Emergency Care</b> <b>\$100</b> Emergency Room copayment for each visit – waived if admitted	<b>25%</b> of negotiated fee <sup>3</sup>	<b>25%</b> of customary and reasonable charges plus <b>100%</b> of excess charges for first 48 hours; after 48 hours, all charges in excess of \$650 per day <sup>3</sup>
<b>Ambulance</b>	<b>25%</b> of negotiated fee <sup>3</sup>	<b>50%</b> of negotiated fee <sup>3</sup> plus <b>100%</b> of excess charges
<b>Skilled Nursing Facility</b> 100 days per year, in-network and out-of-network combined; Preservice Review required	<b>25%</b> of negotiated fee <sup>3</sup>	All charges in excess of \$150 per day <sup>3</sup>
<b>Home Health Care</b> 100 four-hour visits per year; in-network and out-of-network combined; Preservice Review required	<b>25%</b> of negotiated fee <sup>3</sup>	All charges in excess of \$75 per visit <sup>3</sup>
<b>Physical/Occupational Therapy, Chiropractic Care</b> 12 visits per year, in-network and out-of-network combined	<b>25%</b> of negotiated fee <sup>3</sup>	All charges in excess of \$25 per visit <sup>3</sup>
<b>Acupuncture/Acupressure</b> 24 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 <sup>3</sup>	All charges in excess of \$25 per visit <sup>3</sup>
<b>Mental Health/Inpatient<sup>5</sup></b> 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 <sup>3</sup>	All charges in excess of \$175 per day <sup>3</sup>
<b>Mental Health/Outpatient professional services<sup>5</sup></b> 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 <sup>3</sup>	All charges in excess of \$25 per visit <sup>3</sup>
<b>Infusion Therapy</b> Includes chemotherapy Preservice Review required	<b>25%</b> of negotiated fee <sup>3</sup>	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 <sup>3</sup>
<b>Infertility Services</b> Maximum lifetime Blue Cross payment \$2,000, in-network and out-of-network combined	<b>\$500</b> copay plus <b>25%</b> of the balance of negotiated fee <sup>3</sup>	<b>\$500</b> copay plus <b>50%</b> of the balance of negotiated fee plus <b>100%</b> of charges in excess of negotiated fee <sup>3</sup>

<sup>4</sup> 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.

<sup>5</sup> 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](http://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 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 and 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.

# Comprehensive Benefits and Predictable Costs

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. You get a financially savvy cost structure and comprehensive health benefit, including:

- Access to over 50,000 California network doctors and specialists and over 400 hospitals – so you're covered just about anywhere
- \$35 copay for Doctors' Office Visits (after First Dollar Coverage and Annual Deductible)
- 25% of negotiated fee for Inpatient and Outpatient Hospital Charges
- Maternity Coverage
- Prescription Drugs: \$10 generic; \$30 brand-name after \$250 brand-name deductible
- Preventive Care for the whole family



**BC Life & Health**  
Insurance Company

HealthyExtensions<sup>SM</sup> and Baby Connection<sup>SM</sup> 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. The WebMD Web site is owned and operated by WebMD Health Corp. WebMD Health is solely responsible for its Web site and is not affiliated with Blue Cross of California or any affiliate of Blue Cross of California.

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