



BlueCross
of California



Select HMO, HMO Saver and Individual HMO Plans

Individual and Family Health Care Plans for California

HMO Plans

If you enroll in one of our HMO plans, you'll choose a primary care physician who will coordinate your health care services and authorize referrals to any specialists you may need.

Which HMO Plan is for you?

Select HMO

- Exclusive network of doctors and hospitals in 22 California counties
- Comprehensive HMO coverage with lower monthly premiums
- Immediate, no-deductible benefits
- Brand-name and generic prescription drug coverage
- Maternity benefits

What else do you get?

- Access to nearly 15,000 California network doctors and specialists and nearly 400 hospitals in
- 22 California counties - **bringing comprehensive HMO coverage closer to more people**
- **Money in your pocket** - because we've negotiated lower fees with our network doctors and hospitals, your share of costs is less (a lot less)
- Out-of-state coverage **for emergency and urgent care**

Note: If your doctor doesn't participate in the Select HMO Network, ask your Blue Cross agent about our HMO Saver or Individual HMO Plan.

Select HMO, HMO Saver and Individual HMO Plans

HMO Saver

- Comprehensive HMO coverage
- \$1,500 medical deductible for hospital and emergency services helps keep monthly premiums lower
- Brand-name and generic prescription drug coverage
- Maternity benefits

Individual HMO

- Comprehensive HMO coverage
- Immediate, no-deductible benefits
- Brand-name and generic prescription drug coverage
- Maternity benefits

What else do you get with these two HMOs?

- Access to over 30,000 California network doctors and specialists and nearly 400 hospitals – **so chances are your doctor is one of ours**
- **Money in your pocket** – because we've negotiated lower fees with our network doctors and hospitals, your share of costs is less (a lot less)
- Out-of-state coverage **for emergency and urgent care**

Be sure to also check out our dental plans and life insurance on pages 10 and 11.

Note: Both the HMO Saver and Individual HMO offer rich benefits. Choose the HMO Saver if you want lower monthly premiums and don't mind meeting a \$1,500 deductible. Choose the Individual HMO if you want immediate, no-deductible benefits.

Without health coverage, you could pay an average of \$29,968 for a 3-day hospital stay. Don't wait to get the protection you need.

Select HMO Plan

These amounts show your share of costs after deductibles, if any

Benefit	In-Select Network
Annual Deductible	\$0
Lifetime Maximum	Unlimited
Annual Out-of-Pocket Maximum	\$3,000 per member; Once two members each reach the maximum, the maximum is satisfied for the entire family
Doctors' Office Visits	\$25 copay
Professional Services (X-ray, lab, anesthesia, surgeon, etc.)	No charge for office visit-related services
Hospital Inpatient (Overnight Hospital Stays)	\$250 copay per day up to the first four days, then covered at 100% of negotiated fee per admission
Hospital Outpatient (If You Don't Stay Overnight)	20% of negotiated fee for services; \$250 per surgery
Emergency Room Services ¹	20% of negotiated fee
Maternity	Office Visits: \$25 copay Hospital Inpatient: \$250 per day copay up to the first four days, then covered at 100% of negotiated fee per admission Outpatient Services: 20% of negotiated fee
Preventive Care	\$25 copay for specific health maintenance services
Ambulance	\$50 copay, waived if admitted to hospital
Physical/Occupational Therapy; Chiropractic Services (Up to 60 consecutive days following an illness or injury)	Outpatient: \$25 copay per visit Inpatient: \$0 Chiropractic services provided with medical group referral only
Acupuncture/Acupressure	Not covered
Prescription Drug Benefits (Blue Cross Formulary ²) Amounts shown are for each 30-day retail or in-network mail order supply	\$10 copay generic; \$30 copay brand-name ³ after \$250 brand-name prescription drug deductible (2-member maximum); 30% of negotiated fee for self-administered injectables, except insulin

¹ Additional \$100 copay applies for each emergency room visit. Waived if admitted as inpatient.

² Non-Formulary Drugs: You pay 50% for generic, 100% for brand-name up to the brand-name deductible, then either: 50% if no generic is available, or generic copay plus the difference between brand-name and available generic equivalent.

³ 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.

Notes:

- This plan does not cover services by non-participating providers except for emergency services and prescription drugs.
- The brand-name drug deductible does not apply to the out-of-pocket maximum.
- Self-administered injectables, except insulin, are not available through mail order.

HMO Saver & Individual HMO Plans

These amounts show your share of costs after deductibles, if any

Benefit	HMO Saver In-Network	Individual HMO In-Network
Annual Deductible	\$1,500 per member: Inpatient/Outpatient Hospital Services and Ambulatory Surgical Centers	\$0
Lifetime Maximum	Unlimited	Unlimited
Annual Out-of-Pocket Maximum (In addition to deductible)	\$1,500 per member; Once two members each reach the maximum, the maximum is satisfied for the entire family (includes deductible)	\$1,500 per member; Once two members each reach the maximum, the maximum is satisfied for the entire family
Doctors' Office Visits	\$10 copay per visit	\$10 copay per visit
Professional Services (X-ray, lab, anesthesia, surgeon, etc.)	No charge for office visit-related services	No charge for office visit-related services
Hospital Inpatient (Overnight Hospital Stays)	20% of negotiated fee (after deductible)	20% of negotiated fee
Hospital Outpatient (If You Don't Stay Overnight)	20% of negotiated fee (emergency and non-emergency services are subject to the deductible)	20% of negotiated fee
Emergency Room Services¹	20% of negotiated fee (after deductible)	20% of negotiated fee
Maternity	Office visits: \$10 copay; Inpatient/Outpatient: After deductible, 20% of negotiated fee	Office visits: \$10 copay; Inpatient/Outpatient: 20% of negotiated fee
Preventive Care	\$10 copay for specific health maintenance services	\$10 copay for specific health maintenance services
Ambulance	\$50 copay; waived if admitted to the hospital	\$50 copay; waived if admitted to the hospital
Physical/Occupational Therapy; Chiropractic Services (Up to 60 consecutive days following an illness or injury)	Outpatient: \$10 copay per visit Inpatient: 20% of negotiated fee Chiropractic services provided with medical group referral only	Outpatient: \$10 copay per visit Inpatient: 20% of negotiated fee Chiropractic services provided with medical group referral only
Acupuncture/Acupressure	Not covered	Not covered
Prescription Drug Benefits (Blue Cross Formulary²) Amounts shown are for each 30-day retail or in-network mail order supply	\$10 copay generic; \$30 copay brand-name ³ after \$250 brand-name prescription drug deductible (2-member maximum); 30% of negotiated fee for self- administered injectables, except insulin	\$10 copay generic; \$30 copay brand-name ³ after \$250 brand-name prescription drug deductible (2-member maximum); 30% of negotiated fee for self- administered injectables, except insulin

¹ Additional \$100 copay applies for each emergency room visit. Waived if admitted as inpatient.

² Non-Formulary Drugs: You pay 50% for generic, 100% for brand-name up to the brand-name deductible, then either: 50% if no generic is available, or generic copay plus the difference between brand-name and available generic equivalent.

³ 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.

In order to receive HMO benefits, you must choose a provider within a 30-mile radius of your home or work.

What the Medical Plans Do Not Cover

Please take a few moments to review the exclusions and limitations. We want you to understand what your coverage does not include before you enroll.

These listings are an overview only. The Select HMO/HMO Saver/Individual HMO Evidence of Coverage and Disclosure Form/Certificate (EOC) contains a comprehensive list of the plans' exclusions and limitations. For a sample copy of an EOC, ask your agent or contact Blue Cross of California.

Exclusions and Limitations

- 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.
- 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) as specifically stated in the Evidence of Coverage and Disclosure Form/Certificate.
- 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.
- Services or supplies related to a preexisting condition.
- 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 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.
- Growth hormone treatment.
- Acupuncture/Acupressure.
- Chiropractic services.
- Immunizations for foreign travel.
- Treatment for chronic alcoholism or other substance abuse except as specifically stated in the Evidence of Coverage and Disclosure Form.
- Inpatient mental care, including acute alcoholism and drug addiction benefits, except detoxification.
- Treatment of mental and nervous disorders, except as specifically stated in the Evidence of Coverage and Disclosure Form.
- Rehabilitative care specifically stated in the Evidence of Coverage and Disclosure Form.
- Reconstructive surgery, purchase or replacement of artificial limbs or prosthesis except as specifically stated in the Evidence of Coverage and Disclosure Form.
- Medical, surgical and/or psychological treatment of a sexual dysfunction, except when a sexual dysfunction is a result of a physical abnormality, defect or disease.
- Medical, surgical services, supplies or treatment to the joint of the jaw (temporomandibular joint), upper jaw (maxilla) or lower jaw (mandible), unless related to a tumor or accident occurring while covered.
- Routine physical examinations or tests that do not directly treat an acute illness, injury or condition unless authorized by your Primary Care Physician, except in no event will any physical examination or test required by employment or government authority, or at the request of a third party, such as a school, camp or sports-affiliated organization, be covered unless Medically Necessary.
- Care or treatment of a pregnancy, or any condition related to pregnancy (except treatment of complications of pregnancy or Cesarean-section deliveries) when conception has occurred before the effective date of the plan agreement. However, if you were covered under Creditable Coverage within 63 days of becoming covered, the time spent under Creditable Coverage will be used to satisfy, or partially satisfy, the six (6) month period.

General Provisions

Mental Health Coverage

Blue Cross provides the same level of coverage as other medical diagnoses for the medically necessary treatment of severe mental illnesses in persons of any age. Severe mental illness, as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM), includes the following diagnoses:

- Schizophrenia
- Schizoaffective disorder
- Bipolar disorder (manic-depressive illness)
- Major depressive disorders
- Panic disorder
- Obsessive-compulsive disorder
- Pervasive developmental disorder or autism
- Anorexia nervosa
- Bulimia nervosa

Blue Cross also provides the same level of coverage as other medical diagnoses for serious emotional disturbances in children that result in behavior inappropriate to the child's age, according to expected developmental norms.

For more details regarding these benefits, refer to the Evidence of Coverage booklets.

Emergency Care

Blue Cross covers emergency services necessary to screen and stabilize your condition. No authorization or precertification is required if you reasonably believe an emergency medical condition exists. A medical emergency is an unexpected acute illness, injury or condition that could endanger your health if not treated immediately. Examples of medical emergencies include:

- Severe pain
- Chest pains
- Heavy bleeding
- Difficulty breathing or shortness of breath
- Sudden loss of consciousness
- Sudden weakness or numbness of the face, arm or leg on one side of the body

When you consider a medical condition to be an emergency, immediately call 911 or go to the nearest hospital emergency room. Once your condition is stabilized, it is important for the hospital, you or a family member to contact your physician or Blue Cross about the authorization of additional services.

For emergency services, the service area is a 20-mile radius from your participating medical group. If you need emergency treatment and you are more than 20 miles from your Primary Care Physician's office or more than 20 miles from your Medical Group, you should seek immediate care. If, as a result of the emergency condition, you are admitted to the hospital through the emergency room, you or a member of your family must notify Blue Cross as soon as possible but no later than 48 hours after initial care has been provided, unless extraordinary circumstances prevent such notification.

Rights and Obligations

No-Obligation Review Period

After you enroll in a plan offered by Blue Cross of California, you will receive a Policy/EOC 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 Policy/EOC booklet along with a letter notifying us that you wish to discontinue coverage. Policy/EOC booklets are available for you to examine prior to enrolling. Ask your agent or Blue Cross.

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 can call 1-800-333-0912.

Utilization Management and Pre-Service Review

The Blue Cross Utilization Management and Pre-Service Review Program helps members receive coverage for appropriate treatment in the appropriate setting. Four review processes are included:

1. Pre-Service 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 Pre-Service 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 Management and Pre-Service 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.

Requirement for Binding Arbitration

If you are applying for coverage, please note that Blue Cross requires binding arbitration to settle **any and all** disputes including medical malpractice, breach of contract and benefits. This means that you are waiving your right to a jury or court trial for **both** medical malpractice claims and any other disputes. 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.

Department of Managed Health Care

The Department of Managed Health Care is responsible for regulating health care service plans, including Blue Cross of California. 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 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 (888) HMO-2219 and a 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.

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 81.53 percent. This ratio was calculated after provider discounts were applied.

Enrollment Guidelines

To enroll, you and/or your dependents must be:

- Age 64¾ or younger;
- A permanent legal resident of California;
- A U.S. resident for at least the last 3 months;
- The applicant's spouse or domestic partner, age 64¾ or younger;
- The applicant's children (under 19 years of age), or the children (under 19 years of age) of the applicant's enrolling spouse or qualified domestic partner;
- The applicant's unmarried dependent children between the ages of 19 through 22 ("dependent" as defined by the Internal Revenue Service);
- The applicant's child (of any age) who is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition and is chiefly dependent upon the applicant for support and maintenance.

Medical Underwriting Requirement

We believe that the cost of our plans should be consistent with a member's expected health care needs and risk factors. That's why Blue Cross offers various levels of coverage. To determine individual medical risk factors, all applications are subject to medical underwriting. Depending on the results of the underwriting review, a number of things may happen:

- You may be offered coverage at the standard premium charge, or
- You may be offered the plan you selected at a higher rate, or
- You may not qualify for the plan listed in this brochure, or
- You may be offered an alternate plan.

If you have a significant medical condition and do not qualify for the plan in this brochure or if you have discontinued group coverage, please contact your Blue Cross representative for information regarding other Individual coverage options.

Terms of Coverage

Coverage remains in force as long as you pay the required premiums on time, live or work within 30 miles from a Blue Cross of California HMO or Select HMO Network provider, and you remain eligible for membership. Coverage will cease if you become ineligible because of residency requirements or duplicate Individual coverage with Blue Cross.

Blue Cross may change or terminate coverage for all covered persons with the same plan, rating area and deductible (if applicable), including changing rates, with 30 days prior written notice. Blue Cross does not change coverage or rates unless the change applies to all covered persons of the same class.

Give yourself every advantage...

good health, a bright smile



Why Dental Coverage?

We believe that a good dental plan should:

- Provide quality coverage at affordable rates
- Help minimize the cost of expensive dental care
- Contribute to your overall health

Improve your quality of life, self-confidence and appearance by making good oral health a part of your daily routine and by taking advantage of the benefits offered through our dental plans. Whether you choose the flexibility of our Dental Blue® PPO plan from BC Life & Health Insurance Company or comprehensive coverage at a lower cost with our Dental SelectHMOSM plans from Blue Cross of California, you'll get the benefits you need from a company you can trust.

And our rates are so affordable, they'll make you smile!

and financial security.



Why Term Life Insurance?

Losing a loved one is hard enough without having to worry about financial obligations. Families are often unprepared for this sudden loss, and term life insurance can provide financial support and peace of mind at a difficult time. Here are just a few reasons why you'll want to purchase term life insurance from BC Life & Health Insurance Company:

- It's inexpensive – just pennies a day
- It's easy – no additional forms are required to enroll
- It's convenient – your life and health plan premiums will be on the same bill

For more information on our dental plans or life insurance, ask your Blue Cross agent today!

Term Life Monthly Rates					
Age	\$15,000 benefit	\$30,000 benefit	\$50,000 benefit	\$75,000 benefit	\$100,000 benefit
1-18	\$1.50	\$3.00	N/A	N/A	N/A
19-29	\$2.80	\$5.60	\$9.30	\$11.25	\$13.00
30-39	\$3.25	\$6.50	\$10.80	\$13.50	\$16.00
40-49	\$7.50	\$15.00	\$25.00	\$33.75	\$42.00
50-59	\$20.90	\$41.80	\$69.60	\$97.50	\$125.00
60-65	\$29.40	\$58.80	\$98.00	\$142.50	\$185.00

Ready to Enroll?
Call Your Blue Cross Agent Today!



Blue Cross of California (BCC) and BC Life & Health Insurance Company (BCL&H) are Independent Licensees of the Blue Cross Association (BCA). Dental Blue and the Blue Cross name and symbol are registered service marks of the BCA. The following plans are offered by BCC: PPO Share 2500/1500/1000/500, Individual HMO, HMO Saver, EPO and Dental SelectHMO. The following plans are offered by BCL&H: CORE 5000, Basic PPO 1000/2500, PPO Saver, PPO Share 5000/1000/500, RightPlan PPO 40, 3500 Deductible PPO, PPO 3500 (HSA-Compatible), Short-Term PPO, Tonik, Term Life and Dental Blue.

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Benefits effective 3/1/08

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