BlueCross of California

BC Life & Health Insurance Company

PPO Share Plans

Individual and Family Health Care Plans for California

Is a PPO Share Plan for you?

- **Our most comprehensive PPO coverage – simply choose the medical deductible/monthly premium combination that works for you**
- **Immediate benefits for doctors' office visits**
- **Brand-name and generic prescription drug coverage**
- **Maternity benefits**

What else do you get?

- Access to over 50,000 California network doctors and specialists and over 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 – **so you'll feel better wherever you are**

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

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.

PPO Share 1500 Plan

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

Benefit	In-Network	Out-of-Network
Annual Deductible (Combined for In-Network and Out-of-Network)	**$1,500 per member** (Once 2 members each reach the deductible, the deductible is satisfied for the entire family.)	**$1,500 per member** (Once 2 members each reach the deductible, the deductible is satisfied for the entire family.)
Lifetime Maximum (Combined for In-Network and Out-of-Network)	$5,000,000 per member	$5,000,000 per member
Annual Out-of-Pocket Maximum[1] *(In addition to deductible)* (Combined for In-Network and Out-of-Network)	**$4,500 per member** (Once 2 members each reach the maximum, the maximum is satisfied for the entire family.)	**$4,500 per member** (Once 2 members each reach the maximum, the maximum is satisfied for the entire family.)
Doctors' Office Visits	30% of negotiated fee (deductible waived)	50% of negotiated fee plus all excess charges (deductible waived)
Professional Services (X-ray, lab, anesthesia, surgeon, etc.)	30% of negotiated fee	50% of negotiated fee plus all excess charges
Hospital Inpatient **(Overnight Hospital Stays)**	30% of negotiated fee[2]	All charges except $650 per day
Hospital Outpatient **(If You Don't Stay Overnight)**	30% of negotiated fee[2]	All charges except $380 per day
Emergency Room Services[3]	30% of negotiated fee	30% of customary and reasonable fees plus all excess charges
Maternity	30% of negotiated fee	50% of negotiated fee plus all excess charges
Preventive Care	Annual physical exam(s): 30% of negotiated fee* (deductible waived) **OR** HealthyCheck℠ Centers[5]: $25/$75 copay for basic/premium screening (deductible waived)	Annual physical exam(s): 50% of negotiated fee* plus all excess charges (deductible waived)
	Routine mammogram, Pap and PSA tests[4]: 30% of negotiated fee (deductible waived) Well Baby and Well Child (through age 6): 40% of negotiated fee (deductible waived)	Routine mammogram, Pap and PSA tests[4]: 50% of negotiated fee plus all excess charges (deductible waived) Well Baby and Well Child (through age 6): 50% of negotiated fee plus all excess charges (deductible waived)
Ambulance	30% of negotiated fee	50% of negotiated fee plus all excess charges
Physical/Occupational Therapy; **Chiropractic Services**	30% of negotiated fee, up to 12 visits per year[6]	All charges except $25 per visit, up to 12 visits per year[6]
Acupuncture/Acupressure (Combined for In-Network and Out-of-Network)	All charges except $25 per visit, up to 24 visits per year (deductible waived)	All charges except $25 per visit, up to 24 visits per year (deductible waived)
Prescription Drug Benefits **(Blue Cross Formulary[7])** Amounts shown are for each 30-day retail or in-network mail order supply	$10 copay generic; $30 copay brand-name[8] after $250 brand-name prescription drug deductible (2-member maximum); 30% of negotiated fee for self-administered injectables, except insulin	50% of drug limited fee schedule and all excess charges plus the copay/coinsurance as stated for in-network benefits; subject to the annual $250 brand-name prescription drug deductible

[1] Excludes non-participating charges in excess of the Blue Cross negotiated fee and non-participating charges in excess of customary and reasonable fees for emergency care. Copays/coinsurance to participating and non-participating providers apply to out-of-pocket maximum except where specifically noted in the policy.

[2] Additional $500 admission charge at participating hospitals (no additional charge for preferred participating) is for inpatient stays or outpatient surgery or infusion therapy. The charge is not required for ambulatory surgical centers or medical emergencies.

[3] Additional $100 copay applies for each emergency room visit. Waived if admitted as inpatient.

[4] Tests ordered by a physician are covered, including appropriate screening for breast, cervical and ovarian cancer.

[5] One HealthyCheck visit at a HealthyCheck Center only allowed for each 12-month period. HealthyCheck applies only to adults and children age 7 and above.

[6] Visits to participating and non-participating providers combined. Additional visits may be authorized.

[7] 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.

[8] 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.

* Maximum annual physical exam benefit is $200 for members covered more than 6 months; $100 for members covered less than 6 months.

PPO Share 2500 Plan

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

Benefit	In-Network	Out-of-Network
Annual Deductible (Combined for In-Network and Out-of-Network)	**$2,500 per member** (Once 2 members each reach the deductible, the deductible is satisfied for the entire family.)	**$2,500 per member** (Once 2 members each reach the deductible, the deductible is satisfied for the entire family.)
Lifetime Maximum (Combined for In-Network and Out-of-Network)	$5,000,000 per member	$5,000,000 per member
Annual Out-of-Pocket Maximum[1] *(In addition to deductible)* (Combined for In-Network and Out-of-Network)	**$5,000 per member** (Once 2 members each reach the maximum, the maximum is satisfied for the entire family.)	**$5,000 per member** (Once 2 members each reach the maximum, the maximum is satisfied for the entire family.)
Doctors' Office Visits	$35 copay (deductible waived)	50% of negotiated fee plus all excess charges (deductible waived)
Professional Services (X-ray, lab, anesthesia, surgeon, etc.)	30% of negotiated fee	50% of negotiated fee plus all excess charges
Hospital Inpatient **(Overnight Hospital Stays)**	30% of negotiated fee[2]	All charges except $650 per day
Hospital Outpatient **(If You Don't Stay Overnight)**	30% of negotiated fee[2]	All charges except $380 per day
Emergency Room Services[3]	30% of negotiated fee	30% of customary and reasonable fees plus all excess charges
Maternity	30% of negotiated fee	50% of negotiated fee plus all excess charges
Preventive Care	Annual physical exam(s): 30% of negotiated fee* (deductible waived) **OR** HealthyCheck℠ Centers[5]: $25/$75 copay for basic/premium screening (deductible waived)	Annual physical exam(s): 50% of negotiated fee* plus all excess charges (deductible waived)
	Routine mammogram, Pap and PSA tests[4]: 30% of negotiated fee (deductible waived) Well Baby and Well Child (through age 6): 40% of negotiated fee (deductible waived)	Routine mammogram, Pap and PSA tests[4]: 50% of negotiated fee plus all excess charges (deductible waived) Well Baby and Well Child (through age 6): 50% of negotiated fee plus all excess charges (deductible waived)
Ambulance	30% of negotiated fee	50% of negotiated fee plus all excess charges
Physical/Occupational Therapy; **Chiropractic Services**	30% of negotiated fee, up to 12 visits per year[6]	All charges except $25 per visit, up to 12 visits per year[6]
Acupuncture/Acupressure (Combined for In-Network and Out-of-Network)	All charges except $25 per visit, up to 24 visits per year (deductible waived)	All charges except $25 per visit, up to 24 visits per year (deductible waived)
Prescription Drug Benefits **(Blue Cross Formulary[7])** Amounts shown are for each 30-day retail or in-network mail order supply	$10 copay generic; $30 copay brand-name[8] after $500 brand-name prescription drug deductible (2-member maximum); 30% of negotiated fee for self-administered injectables, except insulin	50% of drug limited fee schedule and all excess charges plus the copay/coinsurance as stated for in-network benefits; subject to the annual $500 brand-name prescription drug deductible

[1] Excludes non-participating charges in excess of the Blue Cross negotiated fee and non-participating charges in excess of customary and reasonable fees for emergency care. Copays/coinsurance to participating and non-participating providers apply to out-of-pocket maximum except where specifically noted in the policy.

[2] Additional $500 admission charge at participating hospitals (no additional charge for preferred participating) is for inpatient stays or outpatient surgery or infusion therapy. The charge is not required for ambulatory surgical centers or medical emergencies.

[3] Additional $100 copay applies for each emergency room visit. Waived if admitted as inpatient.

[4] Tests ordered by a physician are covered, including appropriate screening for breast, cervical and ovarian cancer.

[5] One HealthyCheck visit at a HealthyCheck Center only allowed for each 12-month period. HealthyCheck applies only to adults and children age 7 and above.

[6] Visits to participating and non-participating providers combined. Additional visits may be authorized.

[7] 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.

[8] 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.

* Maximum annual physical exam benefit is $200 for members covered more than 6 months; $100 for members covered less than 6 months.

PPO Share 5000 Plan

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

Benefit	In-Network	Out-of-Network
Annual Deductible (Combined for In-Network and Out-of-Network)	**$5,000 per member** (Once 2 members each reach the deductible, the deductible is satisfied for the entire family.)	**$5,000 per member** (Once 2 members each reach the deductible, the deductible is satisfied for the entire family.)
Lifetime Maximum (Combined for In-Network and Out-of-Network)	$5,000,000 per member	$5,000,000 per member
Annual Out-of-Pocket Maximum[1] *(In addition to deductible)* (Combined for In-Network and Out-of-Network)	**$2,500 per member** (Once 2 members each reach the maximum, the maximum is satisfied for the entire family.)	**$2,500 per member** (Once 2 members each reach the maximum, the maximum is satisfied for the entire family.)
Doctors' Office Visits	$40 copay (deductible waived)	50% of negotiated fee plus all excess charges (deductible waived)
Professional Services (X-ray, lab, anesthesia, surgeon, etc.)	30% of negotiated fee	50% of negotiated fee plus all excess charges
Hospital Inpatient **(Overnight Hospital Stays)**	30% of negotiated fee[2]	All charges except $650 per day
Hospital Outpatient **(If You Don't Stay Overnight)**	30% of negotiated fee[2]	All charges except $380 per day
Emergency Room Services[3]	30% of negotiated fee	30% of customary and reasonable fees plus all excess charges
Maternity	30% of negotiated fee	50% of negotiated fee plus all excess charges
Preventive Care	Annual physical exam(s): 30% of negotiated fee* (deductible waived) **OR** HealthyCheck℠ Centers[5]: $25/$75 copay for basic/premium screening (deductible waived) Routine mammogram, Pap and PSA tests[4]: 30% of negotiated fee (deductible waived) Well Baby and Well Child (through age 6): 40% of negotiated fee (deductible waived)	Annual physical exam(s): 50% of negotiated fee* plus all excess charges (deductible waived) Routine mammogram, Pap and PSA tests[4]: 50% of negotiated fee plus all excess charges (deductible waived) Well Baby and Well Child (through age 6): 50% of negotiated fee plus all excess charges (deductible waived)
Ambulance	30% of negotiated fee	50% of negotiated fee plus all excess charges
Physical/Occupational Therapy; **Chiropractic Services**	30% of negotiated fee, up to 12 visits per year[6]	All charges except $25 per visit, up to 12 visits per year[6]
Acupuncture/Acupressure (Combined for In-Network and Out-of-Network)	All charges except $25 per visit, up to 24 visits per year (deductible waived)	All charges except $25 per visit, up to 24 visits per year (deductible waived)
Prescription Drug Benefits **(Blue Cross Formulary[7])** Amounts shown are for each 30-day retail or in-network mail order supply	$10 copay generic; $35 copay brand-name[8] after $750 brand-name prescription drug deductible (2-member maximum); 30% of negotiated fee for self-administered injectables, except insulin	50% of drug limited fee schedule and all excess charges plus the copay/coinsurance as stated for in-network benefits; subject to the annual $750 brand-name prescription drug deductible

[1] Excludes non-participating charges in excess of the Blue Cross negotiated fee and non-participating charges in excess of customary and reasonable fees for emergency care. Copays/coinsurance to participating and non-participating providers apply to out-of-pocket maximum except where specifically noted in the policy.

[2] Additional $500 admission charge at participating hospitals (no additional charge for preferred participating) is for inpatient stays or outpatient surgery or infusion therapy. The charge is not required for ambulatory surgical centers or medical emergencies.

[3] Additional $100 copay applies for each emergency room visit. Waived if admitted as inpatient.

[4] Tests ordered by a physician are covered, including appropriate screening for breast, cervical and ovarian cancer.

[5] One HealthyCheck visit at a HealthyCheck Center only allowed for each 12-month period. HealthyCheck applies only to adults and children age 7 and above.

[6] Visits to participating and non-participating providers combined. Additional visits may be authorized.

[7] 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.

[8] 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.

* Maximum annual physical exam benefit is $200 for members covered more than 6 months; $100 for members covered less than 6 months.

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 PPO Share Plans booklets contain a comprehensive list of the plans' exclusions and limitations. For a sample copy of a Policy/Combined Evidence of Coverage and Disclosure Form (EOC) booklet, ask your agent or contact Blue Cross of California/BC Life & Health Insurance Company.

Exclusions and Limitations

- 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 Policy/EOC.
- 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), except as specifically stated in the Policy/EOC.
- Any amounts in excess of the maximum amounts listed in the Policy/EOC.
- 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 Policy/EOC.
- Hearing aids.
- Contraceptive drugs and/or certain contraceptive devices, except as specifically stated in the Policy/EOC.
- Infertility services.
- Private duty nursing.
- Eyeglasses or contact lenses, except as specifically stated in the Policy/EOC.
- Vision care including certain eye surgeries to replace glasses, except as specifically stated in the Policy/EOC.
- Mental and nervous disorders and substance abuse, except as specifically stated in the Policy/EOC.
- Certain orthopedic shoes or shoe inserts, except as specifically stated in the Policy/EOC.
- 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 Policy/EOC.
- Personal comfort items.
- Custodial care.
- Certain genetic testing.
- Outpatient speech therapy, except as specifically stated in the Policy/EOC.
- Any amounts in excess of maximums stated in the Policy/EOC.
- Outpatient drugs, medications or other substances dispensed or administered in any outpatient setting.
- Services or supplies supplied to any person not covered under the Agreement in connection with a surrogate pregnancy.

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 the PPO Share 5000, PPO Share 2500 and PPO Share 1500/1000/500 plans, coverage is provided for non-severe mental and nervous disorders and substance abuse as follows:

· Inpatient Hospital (30 days/year maximum) – You pay all charges except $175/day

· Professional Services (1 visit/day; 20 visits/year maximum) – You pay all charges except $25/visit

For more details regarding these benefits, refer to the Policy booklet.

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.

Rights and Obligations

No-Obligation Review Period

After you enroll in a plan offered by Blue Cross of California or BC Life & Health Insurance Company, 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.

California Department of Insurance

If you have a problem regarding your coverage, please contact BCL&H to resolve the issue. If you are unable to resolve the matter, you may request a review by the California Department of Insurance (CDI) at the following address and telephone number:

California Department of Insurance
Consumer Affairs Bureau
300 South Spring Street, South Tower
Los Angeles, California 90013
1-800-927-HELP (4357).

You may also be eligible for an Independent Medical Review (IMR) of disputed health care services from the California Department of Insurance if you believe that BCL&H has improperly denied, modified, or delayed health care services. A disputed health care service is any health care service eligible for coverage and payment under your plan that has been denied, modified or delayed by BCL&H, in whole or in part because the service is not Medically Necessary.

The IMR process is in addition to any other procedures or remedies that may be available to you. If you need additional information about IMR or require help in completing the form, you may call (818) 234-3353 or you may write to:

Blue Cross of California/
BC Life & Health Insurance Company
P.O. Box 4310
Woodland Hills, CA 91365.

Your BCL&H Policy contains an arbitration clause. Disagreements between you and BCL&H which exceed small claims court jurisdictional limits will be resolved through arbitration. To initiate arbitration, a written request must be submitted to your dedicated processing unit who will provide you with information to initiate arbitration.

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.

Waiting Periods

For the PPO Share 5000, PPO Share 2500 and PPO Share 1500 plans, there is a specific six-month waiting period for coverage of any condition, disease or ailment for which medical advice or treatment was recommended or received within six months preceding the effective date of coverage. If you apply for coverage within 63 days of terminating your membership with another "creditable" health care plan, then you can use your prior coverage for credit toward the six-month waiting period. Blue Cross will credit the time you were enrolled on the previous plan. Consult with your Blue Cross agent or representative if you have a question about the underwriting process.

Terms of Coverage

Coverage remains in force as long as you pay the required premiums on time and for as long as 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 SelectHMO℠ 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

1-877-Look4Life
Barricks Insurance Services
13900 NW Passage #302
Marina Del Rey, CA 90292
http://www.barricksinsurance.com

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.

bluecrossca.com

Benefits effective 3/1/08

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