HIPAA Plans

Health Insurance Portability and Accountability Act of 1996

BlueCross of California

Effective March 1, 2004

www.bluecrossca.com

KEEPING CALIFORNIANS COVERED

Blue Cross HIPAA plans can keep you covered when coverage through an employer-sponsored plan ends. Coverage is guaranteed under one of our HIPAA plans for anyone who qualifies.

Are you eligible?

To qualify for a HIPAA plan, you must:

- have completed a minimum of 18 months of continuous health coverage, most recently under an employer-sponsored group health plan;
- have elected and exhausted continuation of coverage under COBRA or Cal-COBRA, if available;
- have lost coverage within the last 63 days;* and
- not be eligible for Medi-Cal or Medicare, or have any other medical coverage.

** For reasons other than fraud or non-payment of premiums.*

Do you meet enrollment requirements?

To enroll, you must be a permanent legal resident of California and one of the following;

- the applicant's spouse or qualified Domestic Partner who is not Medicare eligible;
- the applicant's children (under 19 years of age), or the children (under 19 years of age) of the enrolling applicant's spouse or qualified Domestic Partner
- the applicant's unmarried dependent child between the ages of 19 and 23 ("dependent" as defined by the Internal Revenue Service).

Note: To qualify as a Domestic Partner you must provide a validated copy of your Declaration of Domestic Partnership issued by the State of California.

What are your HIPAA plan choices?

From Blue Cross of California:

- **HIPAA PPO Share 1500**
  Featuring a $1,500 annual deductible
- **HIPAA PPO Share 2500**
  Featuring a $2,500 annual deductible

From BC Life & Health Insurance Company:

- **BC Life & Health HIPAA PPO Share 5000**
  Featuring a $5,000 annual deductible
- **BC Life & Health HIPAA Basic PPO 1000**
  Featuring a $1,000 annual deductible for inpatient or surgical procedures only

HIPAA PLANS: OVERVIEW OF COVERAGE *…and your share of costs*

Your Plan Features	HIPAA PPO Share 1500 (R416)		HIPAA PPO Share 2500 (R415)	
	Participating Provider	*Non-participating Provider*	*Participating Provider*	*Non-participating Provider*
Lifetime Maximum	$5,000,000		$5,000,000	
Annual Out-of-Pocket Maximum *(includes deductible)*	$6000/ single (2-member maximum): participating and non-participating combined[1]		$7500/ single (2-member maximum); participating and non-participating combined[1]	
Annual Deductible *(applies to above Out-of-Pocket Maximum)*	$1,500/single (2-member maximum); all covered benefits		$2,500/single (2-member maximum); all covered benefits	
Office Visits	30% of negotiated fee *(deductible waived)*	50% of negotiated fee plus excess for covered expenses *(deductible waived)*	30% of negotiated fee *(deductible waived)*	50% of negotiated fee plus excess for covered expenses *(deductible waived)*
Professional Services *(X-ray, lab, anesthesia, surgeon, etc.)*	30% of negotiated fee	50% of negotiated fee plus excess for covered expenses	30% of negotiated fee	50% of negotiated fee plus excess for covered expenses
Hospital Inpatient/Outpatient	30% of negotiated fee [2]	All charges except $650/day inpatient, $380/day outpatient	30% of negotiated fee [2]	All charges except $650/day inpatient, $380/day outpatient
Emergency Services	30% of negotiated fee[4]	30% of customary & reasonable charges for the first 48 hours plus 100% of excess; after 48 hours, you pay all charges except $650/day for covered services[4]	30% of negotiated fee[4]	30% of customary & reasonable charges for the first 48 hours plus 100% of excess; after 48 hours, you pay all charges except $650/day for covered services[4]
Maternity	30% of negotiated fee	50% of negotiated fee plus 100% of excess	30% of negotiated fee	50% of negotiated fee plus 100% of excess
Preventive Care	Routine mammogram, Pap and PSA tests, ordered by a physician: 30% of negotiated fee *(deductible waived)*; Well-child: 40% of negotiated fee through age 6 *(deductible waived)* HealthyCheck℠ Centers: $25 or $75 copay for basic screenings	Routine mammogram, Pap and PSA ordered by physician: 50% of negotiated fee plus excess *(deductible waived)*; Well-child: 50% of negotiated fee through age 6 *(deductible waived)*	Routine mammogram, Pap, and PSA tests, ordered by a physician: 30% of negotiated fee *(deductible waived)*; Well-child: 40% of negotiated fee through age 6 *(deductible waived)* HealthyCheck℠ Centers: $25 or $75 copay for basic screenings	Routine mammogram, Pap and PSA ordered by physician: 50% of negotiated fee plus excess *(deductible waived)* Well-child: 50% of negotiated fee through age 6 *(deductible waived)*
Drug Benefits* *(Retail or Mail Order: 30-day supply)*	Blue Cross Formulary Drugs:[6] $10 generic, $30 brand-name copay after $250 brand-name deductible[5] (2-member maximum); 30% of negotiated fee for self-administered injectables except insulin	Blue Cross Formulary Drugs:[6] 50% of generic or 50% of brand-name Drug Limited-Fee Schedule within California; $250 brand-name deductible	Blue Cross Formulary Drugs:[6] $10 generic, $30 brand copay after $500 brand-name deductible[5] (2-member maximum); 30% of negotiated fee for self-administered injectables except insulin	Blue Cross Formulary Drugs:[6] 50% of generic or 50% of brand-name Drug Limited-Fee Schedule within California; $500 brand-name deductible

A more detailed listing of coverage can be found in the Evidence of Coverage booklet. For a copy, call your agent or Blue Cross of California at 800-333-0912.

(after deductible)

BC Life HIPAA PPO Share 5000 (R417)		BC Life HIPAA Basic PPO 1000 (PE02)	
Participating Provider	***Non-participating Provider***	***Participating Provider***	***Non-participating Provider***
$5,000,000		$5,000,000	
$7,500/single (2-member maximum); participating and non-participating combined[1]		$3,500/single, only hospital costs apply (2-member maximum); participating and non-participating combined[1]	
$5,000/single (2-member maximum)		$1,000 single, inpatient or surgical procedures only (2-member maximum); all covered benefits	
30% of negotiated fee for office visits *(deductible waived)*	50% of negotiated fee plus excess for covered expenses *(deductible waived)*	No office visit benefit until out-of-pocket maximum is met, then covered at 100% of negotiated fee	No office visit benefit until out-of-pocket maximum is met, then covered at 50% of negotiated fee plus excess for covered expenses
30% of negotiated fee	50% of negotiated fee plus excess for covered expenses	20% of negotiated fee, inpatient or surgical procedures only. No office visit benefits until out-of-pocket maximum is met, then covered at 100% of negotiated fee	50% of negotiated fee, inpatient or surgical procedures. plus excess for covered expenses
30% of negotiated fee[2]	All charges except $650/day inpatient, $380/day outpatient	20% of negotiated fee[2]	All charges except: $650/day inpatient, $380/day outpatient
30% of negotiated fee[4]	30% of customary & reasonable charges for the first 48 hours plus 100% of excess; after 48 hours, member pays all charges except $650/day for covered services[4]	20% of negotiated fee[3]	20% of customary & reasonable for the first 48 hours plus 100% of excess; after 48 hours, you pay all charges except $650/day for covered services[3]
30% of negotiated fee	50% of negotiated fee plus 100% of excess	Not Covered	Not Covered
Routine mammogram, Pap, and PSA tests: 30% of negotiated fee *(deductible waived)* Well Child: 40% of negotiated fee through age 6 *(deductible waived)* HealthyCheck Centers: $25 or $75 copay for basic screenings	Routine mammogram, Pap, and PSA tests: 50% of negotiated fee plus excess *(deductible waived)* Well Child: 50% of negotiated fee through age 6 *(deductible waived)*	Routine mammogram, Pap, and PSA ordered by a physician: 20% of negotiated fee *(deductible waived)* HealthyCheck℠ Centers: $25 or $75 copay for basic screenings	Routine mammogram, Pap, and PSA ordered by a physician: 50% of negotiated fee plus excess *(deductible waived)*
Blue Cross Formulary Drugs:[6] $10 generic; $35 brand-name copay ***after*** $750 brand-name deductible[5] (2-member maximum); 30% of negotiated fee for self-administered injectables, except insulin	Blue Cross Formulary Drugs:[6] 50% generic or 50% of brand-name Drug Limited Fee Schedule within California; $750 brand-name deductible	Not Covered	Not Covered

[1] Non-participating charges in excess of the negotiated fee will not be paid and do not apply to the out-of-pocket maximum.

[2] Additional $500 admission charge at Participating Hospital (no additional charge for Preferred Participating Hospitals) is for surgery or infusion therapy. This charge is not required for Ambulatory Surgical Centers or medical emergencies.

[3] Additional $30 copay applies for each emergency room visit (waived if admitted as inpatient).

[4] Additional $100 copay applies for each emergency room visit (waived if admitted as inpatient).

[5] Brand-name drug deductible does not apply to out-of-pocket maximum.

[6] Non-Formulary Drugs: You pay 50% for generic; 100% for brand-name up to brand-name deductible amount. After that you pay 50% for brand if no generic is available or you pay the generic copay plus the cost difference between the brand name and available generic equivalent drug.

* If a member selects a brand-name drug when a generic equivalent is available, then he or she will pay the generic copay plus the cost difference between the brand-name and available generic equivalent drug, even if the physician writes "dispense as written" or do not substitute" on the prescription. The amount paid does not apply to the member's brand-name deductible.

WHAT THE HIPAA PLANS DO NOT COVER

A more detailed listing can be found in the Evidence of Coverage booklet.

- *Conditions covered by Workers' Compensation or similar laws.*
- *Experimental or investigative care or therapy.*
- *Any services provided by a local, state, county, or federal government agency, including any foreign government.*
- *Services or supplies not specifically listed as covered under the plan agreement.*
- *Services received before your Effective Date or during an inpatient stay that began before your Effective Date.*
- *Services rendered before coverage begins or after coverage ends.*
- *Services or supplies for which no charge is made, or for which no charge would be made if you had no insurance coverage or services for which you are not legally obligated to pay.*
- *Services provided by relatives and professional services received from a person who lives in your home or who is related to you by blood, marriage, or adoption.*
- *Any services to the extent that you are entitled to receive Medicare benefits for those services without payment of additional premium for Medicare coverage. For parts of Medicare requiring additional premium payment, services are excluded for those parts of Medicare the member has enrolled in.*
- *Services or supplies that are not medically necessary, as determined by Blue Cross of California or BC Life & Health.*
- *Routine physical exams, except for preventive care services (e.g., physical exams for insurance, employment, licenses, or school are not covered).*
- *Any amounts in excess of the maximum amounts stated in the Maximum Comprehensive and Copayment/Coinsurance Lists sections of your agreement.*
- *Sex change operations or related treatment and study.*
- *Cosmetic surgery or other services for beautification, including any complications arising from, or the result of, cosmetic surgery, except for reconstructive surgery.**
- *Services primarily for weight reduction or treatment of obesity, or any care which involves weight reduction as the main method of treatment, except medically necessary treatment of morbid obesity.*
- *Dental care and treatment or treatment on or to the teeth and gums — unless covered under accidental injury.*
- *Dental implants.*
- *Hearing aids.*
- *Contraceptive drugs and/or some contraceptive devices, including Norplant and Norplant kits, except injectable contraceptives when administered by a physician. (Oral contraceptives and some contraceptive devices are covered under all plans' prescription benefits except the BC Life HIPAA Basic PPO 1000).*
- *All services related to the evaluation or treatment of infertility, including all tests, consultations, medications, surgical, medical or lab procedures, and reversal of sterilization.*
- *Private-duty nursing, including inpatient or outpatient services of a private-duty nurse.*
- *Eyeglasses or contact lenses unless specified in your plan agreement.*
- *Certain eye surgeries, including those solely for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia), astigmatism, and for farsightedness (presbyopia).*
- *Diagnostic admissions, including inpatient room and board charges in connection with a hospital stay primarily for diagnostic tests that could have been safely performed on an outpatient basis, and inpatient admissions primarily for diagnostic studies when inpatient bed care is not medically necessary.*

*Does not apply to reconstructive surgery to restore a bodily function or to correct a deformity caused by injury or medically necessary reconstructive surgery performed to restore symmetry incident to mastectomy.

- *Mental and nervous disorders, substance abuse, and learning disabilities, except as specifically stated under the benefits sections of the plan agreement.*
- *Orthopedic shoes (except when joined to braces) or shoe inserts, except for limited benefits as stated in the Evidence of Coverage.*
- *Orthodontic services, braces, and other orthodontic appliances.*
- *No payment will be made for services or supplies for the treatment of a Preexisting Condition during a period of six months following your effective date. However, this limitation does not apply to a Federally Eligible Defined Individual or to a child born to or newly adopted by an enrolled Subscriber or spouse. Also, if you were covered under Qualifying Prior Coverage within 62 days of becoming covered under this Agreement, the time spent under the Qualifying Prior Coverage will be used to satisfy, or partially satisfy, the six-month period.*
- *Consultations provided by telephone or facsimile machines.*
- *Educational services, except as specifically provided or arranged by Blue Cross.*
- *Nutritional counseling and food supplements, except as stated in your plan agreement.*
- *No benefits are provided for care and treatment furnished in a non-contracting hospital, except for medical emergencies as specified in your agreement.*
- *Items which are furnished primarily for your personal comfort or convenience: air purifiers, air conditioners, humidifiers, exercise equipment, treadmills, spas, elevators, and supplies for comfort, hygiene, or beautification.*
- *Custodial care. Custodial care is care that does not require the services of trained medical or health professionals, such as, but not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications that are ordinarily self-administered. Domiciliary or rest cures for which facilities and/or services of a general acute hospital are not medically required, including resident treatment centers, are also excluded.*
- *Genetic testing for non-medical reasons or when there is not a medical indication or no family history of genetic abnormality.*
- *Outpatient speech therapy, except following surgery, injury, or otherwise as medically necessary.*
- *Services furnished through outdoor treatment programs.*

Additional Exclusions and Limitations for the BC Life HIPAA Basic PPO 1000 Plan

- *Maternity care.*
- *Preventive benefits, except for Pap and PSA tests, and mammograms, not specifically listed in the plan policy.*
- *Outpatient prescription drugs.*
- *Acupuncture/Acupressure.*
- *Physician office visits and associated costs, except as specifically described in the Certificate.*
- *Physical or occupational medicine or chiropractic services, except those provided during an inpatient hospital confinement.*
- *Eyeglasses and eye examinations.*
- *Benefits for Hospice services are limited to a lifetime maximum of $10,000 per member for participating and non-participating providers combined.*

Additional Exclusions and Limitations for the BC Life HIPAA PPO Share 5000 Plan:

- *Benefits for Hospice services limited to a lifetime maximum of $10,000 per member for participating and non-participating providers combined.*

No-Obligation Review Period

After you enroll in a Blue Cross health plan, you will receive an Evidence of Coverage policy 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 Evidence of Coverage booklet along with a letter notifying us that you wish to discontinue coverage. Evidence of Coverage booklets are available for you to examine prior to enrolling. Ask your agent or Blue Cross.

Once you enroll in a Blue Cross HIPAA plan, you will have 30 days from the date of enrollment to change to a different HIPAA plan. Your effective date will be the same as the date of your original enrollment. No further changes will be allowed after you have been enrolled for 30 days.

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 may call 1-800-333-0912

Requirements for Binding Arbitration

If you are applying for coverage, please note that Blue Cross requires binding arbitration to settle all disputes, including claims of medical malpractice. 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.

Grievances

All complaints and disputes relating to your coverage must be resolved in accordance with Blue Cross' grievance procedure. Grievances may be made by telephone or in writing; the phone number and address are located in your Evidence of Coverage and Disclosure Form. All grievances received by Blue Cross will be answered in writing, together with a description of how Blue Cross proposes to resolve the grievance.

Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans, including Blue Cross of California (but not BC Life & Health). 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 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 department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's Internet Web site (http://www.hmohelp.ca.gov) has complaint forms, IMR application forms and instructions on-line.

Third-Party Liability

Blue Cross of California is entitled to reimbursement of benefits paid if you recover damages from a legally liable third party. Examples of third-party liability situations include car accidents and work-related injuries. For complete information about third-party liability, refer to the plan Evidence of Coverage booklet.

Incurred Medical Care Ratio

As required by law, we are advising you that Blue Cross of California's incurred medical care loss ratio for 2003 was 80.81 percent. This loss ratio was calculated after provider discounts were applied.

MONTHLY RATES

Rates for the Blue Cross of California and BCL&H Individual HIPAA Plans are based upon the county in which you reside, and your family status and age. For Subscriber & Spouse and Family, rates are based on the age of the younger spouse. To determine your rate, find your county in the Rating Areas chart below and the rate for your area and category on the rate tables. Rates are recalculated at each billing period based on age and the residence address.

Rating Areas

Area 1: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Mendocino, Modoc, Mono, Monterey, Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo, Yuba

Area 2: Fresno, Imperial, Kern, Madera, Mariposa, Merced, Napa, Sacramento, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Sonoma, Stanislaus

Area 3: Alameda, Contra Costa, Marin, San Francisco, San Mateo, Santa Clara

Area 4: Orange, Santa Barbara, Ventura

Area 5: Los Angeles

Area 6: Riverside, San Bernardino, San Diego

Payment Methods

You may choose one of the following payment methods:

- Monthly billing—available with Monthly Checking Account Automatic Premium Payment Authorization authorization only
- Bimonthly (two-month) billing
- Quarterly (three-month) billing

See page 3 of the application for instructions regarding your first premium payment.

MONTHLY RATES

	Age Range	HIPAA PPO Share 2500 (R415)					
		Area 1	Area 2	Area 3	Area 4	Area 5	Area 6
Single	< 15	$225	$206	$208	$215	$212	$204
	15-29	$254	$238	$241	$229	$230	$212
	30-34	$339	$299	$307	$305	$298	$289
	35-39	$381	$338	$343	$353	$344	$335
	40-44	$480	$420	$432	$433	$426	$392
	45-49	$546	$471	$478	$495	$483	$453
	50-54	$668	$579	$594	$611	$593	$547
	55-59	$807	$703	$719	$728	$707	$647
	60-64	$807	$703	$719	$728	$707	$647
Subscriber & Spouse	15-29	$533	$483	$488	$492	$479	$453
	30-34	$652	$577	$596	$606	$586	$563
	35-39	$713	$631	$646	$658	$646	$620
	40-44	$867	$761	$786	$799	$784	$709
	45-49	$965	$847	$866	$887	$874	$795
	50-54	$1,189	$1,035	$1,066	$1,092	$1,070	$973
	55-59	$1,456	$1,260	$1,293	$1,309	$1,274	$1,166
	60-64	$1,456	$1,260	$1,293	$1,309	$1,274	$1,166
Subscriber & Child	15-29	$533	$483	$488	$492	$479	$453
	30-34	$652	$577	$596	$606	$586	$563
	35-39	$713	$631	$646	$658	$646	$620
	40-44	$867	$761	$786	$799	$784	$709
	45-49	$965	$847	$866	$887	$874	$795
	50-54	$1,189	$1,035	$1,066	$1,092	$1,070	$973
	55-59	$1,456	$1,260	$1,293	$1,309	$1,274	$1,166
	60-64	$1,456	$1,260	$1,293	$1,309	$1,274	$1,166
Family	15-29	$833	$780	$781	$798	$761	$742
	30-34	$993	$910	$925	$965	$917	$884
	35-39	$1,085	$979	$998	$1,057	$998	$954
	40-44	$1,299	$1,123	$1,151	$1,190	$1,155	$1,095
	45-49	$1,395	$1,205	$1,239	$1,266	$1,232	$1,160
	50-54	$1,644	$1,420	$1,456	$1,504	$1,452	$1,361
	55-59	$1,945	$1,679	$1,703	$1,763	$1,686	$1,587
	60-64	$1,945	$1,679	$1,703	$1,763	$1,686	$1,587
Subscriber & Children	15-29	$833	$780	$781	$798	$761	$742
	30-34	$993	$910	$925	$965	$917	$884
	35-39	$1,085	$979	$998	$1,057	$998	$954
	40-44	$1,299	$1,123	$1,151	$1,190	$1,155	$1,095
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	55-59	$1,945	$1,679	$1,703	$1,763	$1,686	$1,587
	60-64	$1,945	$1,679	$1,703	$1,763	$1,686	$1,587

	Age Range	HIPAA PPO Share 1500 (R416)					
		Area 1	Area 2	Area 3	Area 4	Area 5	Area 6
Single	< 15	$225	$206	$208	$215	$212	$204
	15-29	$254	$238	$241	$229	$230	$212
	30-34	$339	$299	$307	$305	$298	$289
	35-39	$381	$338	$343	$353	$344	$335
	40-44	$480	$420	$432	$433	$426	$392
	45-49	$546	$471	$478	$495	$483	$453
	50-54	$668	$579	$594	$611	$593	$547
	55-59	$807	$703	$719	$728	$707	$647
	60-64	$807	$703	$719	$728	$707	$647
Subscriber & Spouse	15-29	$533	$483	$488	$492	$479	$453
	30-34	$652	$577	$596	$606	$586	$563
	35-39	$713	$631	$646	$658	$646	$620
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	45-49	$965	$847	$866	$887	$874	$795
	50-54	$1,189	$1,035	$1,066	$1,092	$1,070	$973
	55-59	$1,456	$1,260	$1,293	$1,309	$1,274	$1,166
	60-64	$1,456	$1,260	$1,293	$1,309	$1,274	$1,166
Subscriber & Child	15-29	$533	$483	$488	$492	$479	$453
	30-34	$652	$577	$596	$606	$586	$563
	35-39	$713	$631	$646	$658	$646	$620
	40-44	$867	$761	$786	$799	$784	$709
	45-49	$965	$847	$866	$887	$874	$795
	50-54	$1,189	$1,035	$1,066	$1,092	$1,070	$973
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Family	15-29	$833	$780	$781	$798	$761	$742
	30-34	$993	$910	$925	$965	$917	$884
	35-39	$1,085	$979	$998	$1,057	$998	$954
	40-44	$1,299	$1,123	$1,151	$1,190	$1,155	$1,095
	45-49	$1,395	$1,205	$1,239	$1,266	$1,232	$1,160
	50-54	$1,644	$1,420	$1,456	$1,504	$1,452	$1,361
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Subscriber & Children	15-29	$833	$780	$781	$798	$761	$742
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	35-39	$1,085	$979	$998	$1,057	$998	$954
	40-44	$1,299	$1,123	$1,151	$1,190	$1,155	$1,095
	45-49	$1,395	$1,205	$1,239	$1,266	$1,232	$1,160
	50-54	$1,644	$1,420	$1,456	$1,504	$1,452	$1,361
	55-59	$1,945	$1,679	$1,703	$1,763	$1,686	$1,587
	60-64	$1,945	$1,679	$1,703	$1,763	$1,686	$1,587

The HIPAA PPO Share 2500 plan and HIPAA PPO Share 1500 are offered by Blue Cross of California.

Notes:
For Subscriber & Spouse and Family, rates are based on the age of the younger spouse.
For more information, call your agent or Blue Cross of California at 800-333-0912.

	Age Range	HIPAA PPO Share 5000 (R417)					
		Area 1	Area 2	Area 3	Area 4	Area 5	Area 6
Single	< 15	$225	$206	$208	$215	$212	$204
	15-29	$254	$238	$241	$229	$230	$212
	30-34	$339	$299	$307	$305	$298	$289
	35-39	$381	$338	$343	$353	$344	$335
	40-44	$480	$420	$432	$433	$426	$392
	45-49	$546	$471	$478	$495	$483	$453
	50-54	$668	$579	$594	$611	$593	$547
	55-59	$807	$703	$719	$728	$707	$647
	60-64	$807	$703	$719	$728	$707	$647
Subscriber & Spouse	15-29	$533	$483	$488	$492	$479	$453
	30-34	$652	$577	$596	$606	$586	$563
	35-39	$713	$631	$646	$658	$646	$620
	40-44	$867	$761	$786	$799	$784	$709
	45-49	$965	$847	$866	$887	$874	$795
	50-54	$1,189	$1,035	$1,066	$1,092	$1,070	$973
	55-59	$1,456	$1,260	$1,293	$1,309	$1,274	$1,166
	60-64	$1,456	$1,260	$1,293	$1,309	$1,274	$1,166
Subscriber & Child	15-29	$533	$483	$488	$492	$479	$453
	30-34	$652	$577	$596	$606	$586	$563
	35-39	$713	$631	$646	$658	$646	$620
	40-44	$867	$761	$786	$799	$784	$709
	45-49	$965	$847	$866	$887	$874	$795
	50-54	$1,189	$1,035	$1,066	$1,092	$1,070	$973
	55-59	$1,456	$1,260	$1,293	$1,309	$1,274	$1,166
	60-64	$1,456	$1,260	$1,293	$1,309	$1,274	$1,166
Family	15-29	$833	$780	$781	$798	$761	$742
	30-34	$993	$910	$925	$965	$917	$884
	35-39	$1,085	$979	$998	$1,057	$998	$954
	40-44	$1,299	$1,123	$1,151	$1,190	$1,155	$1,095
	45-49	$1,395	$1,205	$1,239	$1,266	$1,232	$1,160
	50-54	$1,644	$1,420	$1,456	$1,504	$1,452	$1,361
	55-59	$1,945	$1,679	$1,703	$1,763	$1,686	$1,587
	60-64	$1,945	$1,679	$1,703	$1,763	$1,686	$1,587
Subscriber & Children	15-29	$833	$780	$781	$798	$761	$742
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	60-64	$1,945	$1,679	$1,703	$1,763	$1,686	$1,587

	Age Range	HIPAA Basic PPO 1000 (PE02)					
		Area 1	Area 2	Area 3	Area 4	Area 5	Area 6
Single	<15	$225	$206	$208	$215	$212	$204
	15-29	$254	$238	$241	$229	$230	$212
	30-34	$339	$299	$307	$305	$298	$289
	35-39	$381	$338	$343	$353	$344	$335
	40-44	$480	$420	$432	$433	$426	$392
	45-49	$546	$471	$478	$495	$483	$453
	50-54	$668	$579	$594	$611	$593	$547
	55-59	$807	$703	$719	$728	$707	$647
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Subscriber & Spouse	15-29	$533	$483	$488	$492	$479	$453
	30-34	$652	$577	$596	$606	$586	$563
	35-39	$713	$631	$646	$658	$646	$620
	40-44	$867	$761	$786	$799	$784	$709
	45-49	$965	$847	$866	$887	$874	$795
	50-54	$1,189	$1,035	$1,066	$1,092	$1,070	$973
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	35-39	$713	$631	$646	$658	$646	$620
	40-44	$867	$761	$786	$799	$784	$709
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	55-59	$1,456	$1,260	$1,293	$1,309	$1,274	$1,166
	60-64	$1,456	$1,260	$1,293	$1,309	$1,274	$1,166
Family	15-29	$833	$780	$781	$798	$761	$742
	30-34	$993	$910	$925	$965	$917	$884
	35-39	$1,085	$979	$998	$1,057	$998	$954
	40-44	$1,299	$1,123	$1,151	$1,190	$1,155	$1,095
	45-49	$1,395	$1,205	$1,239	$1,266	$1,232	$1,160
	50-54	$1,644	$1,420	$1,456	$1,504	$1,452	$1,361
	55-59	$1,945	$1,679	$1,703	$1,763	$1,686	$1,587
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Subscriber & Children	15-29	$833	$780	$781	$798	$761	$742
	30-34	$993	$910	$925	$965	$917	$884
	35-39	$1,085	$979	$998	$1,057	$998	$954
	40-44	$1,299	$1,123	$1,151	$1,190	$1,155	$1,095
	45-49	$1,395	$1,205	$1,239	$1,266	$1,232	$1,160
	50-54	$1,644	$1,420	$1,456	$1,504	$1,452	$1,361
	55-59	$1,945	$1,679	$1,703	$1,763	$1,686	$1,587
	60-64	$1,945	$1,679	$1,703	$1,763	$1,686	$1,587

The HIPAA PPO Share 5000 and HIPAA Basic PPO 1000 are offered by BC Life & Health Insurance Company.

Notes:
For Subscriber & Spouse and Family, rates are based on the age of the younger spouse.
For more information, call your agent or Blue Cross of California at 800-333-0912.

BlueCross
of California

The HIPAA PPO Share 2500 and HIPAA PPO Share 1500 Plans are offered by Blue Cross of California. The HIPAA Basic PPO 1000 and the HIPAA PPO 5000 Plans are offered by BC Life & Health Insurance Company.

Blue Cross of California
2000 Corporate Center Drive
Newbury Park, California 91320
www.bluecrossca.com

3962 3/04
Rates effective 1/1/04 and benefits effective 3/1/04

Enrollment Form for Coverage under HIPAA

(Health Insurance Portability and Accountability Act)

HIPAA PPO Share 2500 and HIPAA PPO Share 1500 are offered by Blue Cross of California. BC Life HIPAA Basic PPO 1000 and BC Life HIPAA PPO Share 5000 are offered by BC Life & Health Insurance Company.

1. Enrollee Information

Please print in blue or black ink.

Enrollee's Last Name	First Name	M.I.
Home Address (Must be complete: P.O. Box not acceptable)		
City	State	ZIP Code

2. Choice of Blue Cross Individual Coverage

Choose one plan per enrollment form.

- ☐ BC Life HIPAA Basic PPO 1000 (PE02)
- ☐ BC Life HIPAA PPO Share 5000 (R417)
- ☐ HIPAA PPO Share 2500 (R415)
- ☐ HIPAA PPO Share 1500 (R416)

Billing Address (If different than above.) or P.O. Box	Personal Mail Box (PMB) No.	Daytime Phone No. ( )	Fax Phone No. ( )
City / State / ZIP Code	County *(Required)*	Marital Status ☐ Single ☐ Married	Applicant/Spouse Maiden Name
E-mail Address	If possible, do you want e-mail notification? ☐ Yes ☐ No	Has any person listed on this application resided outside the U.S. for the past three (3) consecutive months? ☐ Yes ☐ No	

Language Choice *(Optional)* ☐ English ☐ Korean ☐ Spanish ☐ Chinese

3. Family Members Enrolling

Please list ALL eligible family members enrolling.

If a listed family member's last name is different from your own, please explain on a separate sheet of paper.

Relation	Last Name	First Name	M.I.	Social Security or ID No.	Date of Birth	Age
10 ☐ Male 20 ☐ Female	Yourself					
30 ☐ Male 40 ☐ Female	Spouse*					
☐ Son ☐ Daughter						
☐ Son ☐ Daughter						
☐ Son ☐ Daughter						
☐ Son ☐ Daughter						

Dependent Information: Do you claim any child listed above who is between the ages of 19 through 22 as a dependent on your Federal Income Tax? ☐ Yes ☐ No

If "No", any child between the ages of 19 through 22 who is not claimed on your Federal Income Tax is NOT eligible as a dependent but may apply individually.

**Spouse includes domestic partner (when applicable). Domestic partner enrollment requires submission of a copy of a valid Declaration of Domestic Partnership filed and stamped by the California Secretary of State.*

1. Have all enrollees had a minimum of 18 months of continuous health coverage most recently under an employer-sponsored group health plan that ended within the last 63 days for a reason other than fraud or non-payment of premium? ..... ☐ Yes ☐ No

   If yes, please attach the Certificate of Creditable Coverage provided by your former employer or carrier OR letter from the employer giving us the start and end date of coverage.

   Name of insurance carrier: _____ Phone No. (_____) _____

   If no for any enrollee, then he or she is not eligible for this guarantee issue plan.

2. Were all enrollees eligible for COBRA or Cal-COBRA? ..... ☐ Yes ☐ No

   If yes, date coverage started (Mo/Day/Yr) _____ Date coverage ended (Mo/Day/Yr) _____

   If no, please explain: _____

   If all available COBRA or Cal-COBRA is not exhausted for any enrollee, then he or she is not eligible for this coverage.

3. Is any enrollee currently covered by or eligible for Medicaid, Medicare or any other employer-sponsored health insurance benefits or does any enrollee have other health coverage? ..... ☐ Yes ☐ No

   If yes for any enrollee, then he or she is not eligible for this coverage.

4. Conditions of Enrollment – IMPORTANT: It is important that you carefully read and fully understand the following:

Effective Date

☐ I request that Blue Cross assign an effective date if this enrollment form is processed. The effective date will be assigned as either the 1st or the 15th of the month following the approval date of this enrollment form.

☐ If Blue Cross processes this enrollment form, please assign an effective date of _____.

Requested effective date must be within 63 days of prior coverage termination date. Blue Cross will allow a retroactive effective date to coincide with the prior coverage termination date.

For HIPAA enrollees, coverage is based upon section 1399.805(b) and payment of premium.

Please allow a minimum of 30 days from the date of this enrollment form for processing.

REQUESTING AN EFFECTIVE DATE DOES NOT GUARANTEE PROCESSING TO BE COMPLETED BEFORE THE DATE REQUESTED.

Agreement

By requesting coverage, I, the undersigned, agree to the following:

1. Blue Cross may decline my enrollment form if I do not qualify, and if so, I will not have any coverage. No coverage comes into effect unless and until Blue Cross processes this enrollment form and notifies me in writing.
2. Even if I pay money with this enrollment form, that money is only a deposit against future premium if this enrollment form is accepted. Cashing my check does not mean my enrollment form is processed. If this enrollment form is declined, neither Blue Cross nor any affiliated company shall have any liability to me, except for the obligation to return the money submitted with this enrollment form. If this enrollment form is not accepted, I will not be entitled to benefits or coverage from Blue Cross.
3. The selling agent has no authority to promise me coverage or to modify Blue Cross underwriting policy or the terms of any Blue Cross coverage.

Requirements for Binding Arbitration

If you are applying for coverage, please note that Blue Cross requires binding arbitration to settle all disputes against Blue Cross, including claims of medical malpractice. 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.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL

Signatures (Required) **– IMPORTANT: All applicants over age 18 must sign and date.**

Enrollee / Parent or Legal Guardian **X**	Today's Date	Enrollee's Spouse **X**	Today's Date
Enrollee age 18 or over **X**	Today's Date	Enrollee age 18 or over **X**	Today's Date

HIV TESTING PROHIBITED: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.

■ **IMPORTANT: All signatures MUST include today's date** ■

ATTACH BLANK, VOIDED CHECK FOR BANK DRAFT AUTHORIZATION, IF APPLICABLE, HERE. DO NOT TAPE.

Applicant's Social Security or ID No.

5. Payment Method **Premium payment required. First payment will be credited to approved applicants only.** By sending your check to us, you authorize Blue Cross of California to convert your check into an electronic fund transfer. If you are approved for coverage, your bank account will be debited for the amount indicated on the check. If you do not qualify for coverage, your check will not be submitted for a funds transfer. Please be aware that your check will not be returned to you.

5A. Credit Card

Fax to: (800) 327-9255

☐ **Initial premium (For new member's Medical and Dental fees only)**
☐ **Monthly premiums**

Monthly Credit Card Authorization - As a convenience to me, I request and authorize you to charge my card for monthly recurring premiums approximately 10 days prior to each due date. I understand that the amount may vary as a result of changes I make, such as, but not limited to, adding and deleting dependents, or moving to a new location. The amount may also change as outlined in my policy. This authority is to remain in effect until revoked by me by providing you a 30-day written notice. I agree that you shall be fully protected in honoring any such card payments. I further agree that if any such card payment be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever, including any fees imposed by my bank, should my card be rejected even though such dishonor results in forfeiture of coverage.

Credit Card: ☐ VISA ☐ MasterCard ☐ Discover

Card No.: Exp. Date: _____

Cardholder's Name PRINT *(As it appears on the credit card)*	Date	Authorized Signature *(As it appears on the credit card)*	Date
X		**X**	

5B. Checking Account Automatic Premium Payment

☐ **Monthly checking account deduction premium payments**

Name of Bank or Financial Institution:

_____

Account No.: Bank Routing No.:

Submit a blank check marked "VOID" above where indicated (DEPOSIT SLIPS NOT ACCEPTABLE). If your application is approved, the premium for all products selected, including dental and/or life, will be deducted from your checking account. Premiums may be prorated in order to adjust the initial paid to date or in the event of membership changes.

Monthly Checking Account Automatic Premium Payment Authorization – As a convenience to me, I request and authorize you to pay and charge to my account checks drawn on that account by and payable to the order of BLUE CROSS OF CALIFORNIA provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such debit shall be the same as if it were a check signed personally by me. I authorize Blue Cross of California to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Blue Cross of California premiums. This authority is to remain in effect until revoked by me by providing you a 30-day written notice. I agree that you shall be fully protected in honoring any such debit. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance. NOTE: Should your withdrawal not be honored by your bank, you will automatically be removed from Monthly Checking Account Automatic Premium Payment and be billed bi-monthly. You will incur a $25 service charge for any withdrawal not honored.

Cardholder's Name PRINT *(As it appears in the financial institution's records)*	Date
X	

5C. Billing (To be used if an automatic payment option is NOT selected from 5A or 5B above.)

☐ **Bi-monthly** (Submit 2 months premium) ☐ **Quarterly** (Submit 3 months premium)

6. Statement of Accountability – Complete when the enrollee cannot fill out the enrollment form for coverage under HIPAA.

I, _____ , personally read and completed this enrollment form for the enrollee named below because:

☐ Enrollee does not read English ☐ Enrollee does not speak English ☐ Enrollee does not write English

☐ Other (explain): _____

I translated the contents of this form and to the best of my knowledge obtained and listed all the requested personal and medical history disclosed by: _____

I also translated and fully explained the "Conditions of Enrollment."

Signature of Translator *(Required)*	Date
X	

7. To the Blue Cross-Appointed Agent or Representative

1. **Your client must personally read and complete this enrollment form. If your client does not read or write English, the Statement of Accountability must be completed.**
2. Did you see the proposed subscriber at the time this enrollment form was executed? ..... ☐ Yes ☐ No
   If no, please explain: _____

Name of Agent *(Print name)*		Agent's Street Address	Suite No.
William Halper / Halper Storz Insurnace Services, Inc.		987 University Ave., Suite 14	
Agent I.D. No. L L M J Q N J Q T Y —		City / State / ZIP Code Los Gatos, CA 95032	
Phone No. (408) 395-3303	Fax No. (408) 395-3363	Signature of Agent *(Required)* **X**	Date *(Required)*

Mail Service Agreement to: ☐ Broker/Agent ☐ Subscriber

PLEASE NOTE: If neither box is checked, the Service Agreement will be mailed directly to the subscriber.

Mailing Address

Enrollee:

Please return this enrollment form to the agent.

Agent:

Please mail to:

Blue Cross of California
P.O. Box 9041
Oxnard, CA 93031-9041

DO NOT WRITE IN THIS AREA