

Individual Plans

Select HMO

Valuable Benefits. Predictable Costs.



BlueCross
of California



Benefits and Rates
Effective October 1, 2004

Select HMO

Valuable Benefits. Predictable Costs.



A New Plan ... and a New Network

To help provide reliable HMO coverage to more individuals and families throughout California, Blue Cross of California is pleased to offer the Individual Select HMO Plan and Network.

The Select HMO Plan and Network were created to give you the security of HMO coverage with easy-to-understand benefits and predictable costs.

With the Select HMO Network, you can choose from more than 13,000 primary care physicians and specialists in 22 California counties. And with the Select HMO Plan, you'll pay just \$25 for office visits. If you're looking for health care coverage with predictable costs and comprehensive, hassle-free benefits, then the Select HMO Plan could be a great choice. This plan is also ideal if you have young children or if you are starting a family.

Partners in Care

With an HMO, you choose a doctor to help guide your medical care. First, you will need to locate a Participating Medical Group (PMG) or Independent Practice Association (IPA) within 30 miles of your home or work. Next, choose a Primary Care Physician (PCP) from the medical group or IPA you have selected. All your care must be provided by or through the PMG/IPA you select, except in an emergency. It's easy to locate a Select HMO Network provider online – just go to www.bluecrossca.com and click on the "Find a Doctor or Hospital (Provider Finder)" link.

Benefits for You and Your Family

Your comprehensive health coverage includes physical exams by your Primary Care Physician and preventive screenings such as Pap tests, mammograms, and testing for prostate cancer. You also have the security of emergency and hospitalization services as well as maternity and prescription drug benefits. And Blue Cross members can access helpful health and wellness information on our Web site at www.bluecrossca.com.

If you're interested in the valuable benefits and predictable costs of the Select HMO Plan, call your Blue Cross agent to sign up today!

Helpful Definitions

Participating Medical Group (PMG) – a group of physicians and specialists in the Select HMO Network who practice in one location and provide most medical services, including X-ray and lab work, at the same location.

Independent Practice Association (IPA) – physicians in the Select HMO Network who practice in their own independent offices and may refer you to a specialist or medical lab at a different location.

Primary Care Physician – the physician you select within your medical group to coordinate your health care needs.

Copay – a set amount you will pay for a specific health care service, such as a \$25 copay for an office visit.

Deductible – the amount you pay each year for covered services before your plan begins paying part of the cost. (The Select HMO plan has no medical deductible.)

Negotiated Fee – the fee for various services that Blue Cross and the participating doctors, specialists and hospitals have agreed upon.

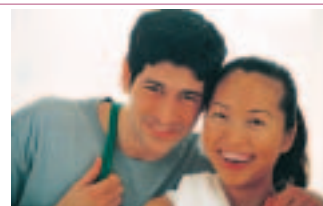
Out-of-Pocket Maximum – the maximum amount for qualifying covered services you would have to spend in any one year before your plan pays 100% of your covered costs for most in-network services.



Select HMO Benefits

All amounts listed are your responsibility to pay unless otherwise noted.

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



Benefit	In-Select Network	Out-of-Select Network
Annual Deductible	None	
Lifetime Maximum	Unlimited	
Annual Out-of-Pocket Maximum	\$3,000 per member; \$6,000 per family (2-member maximum)	Not applicable
Office Visits	\$25 copay	Not covered
Professional Services (X-ray, lab, anesthesia, surgery, etc.)	No charge for office visit related services	Not covered
Hospital Inpatient	\$250 copay per day up to the first four days, then covered at 100% per admission	Not covered
Hospital Outpatient Services	20% of negotiated fee rate	Not covered
Hospital Outpatient Surgery	\$250 per surgery	Not covered
Emergency Services	<p>Professional Services: No charge</p> <p>Inpatient Hospital: \$250 copay per day up to the first four days, then covered at 100% per admission</p> <p>Outpatient Hospital: \$100 emergency room copay plus 20% of negotiated fee rate (waived if admitted to hospital)</p>	<p>Professional Services: No charge</p> <p>Inpatient Hospital: \$250 copay per day up to the first four days, then covered at 100% per admission</p> <p>Outpatient Hospital: \$100 emergency room copay plus 20% of negotiated fee rate (waived if admitted to hospital)</p>
Preventive Care	\$25 copay for specific health maintenance services	Not covered
Ambulance	\$50 copay unless admitted to hospital	Not covered
Physical and Occupational Therapy; Chiropractic Services Up to 60 consecutive days following an illness or injury	<p>Outpatient: \$25 copay per visit</p> <p>Inpatient: No charge</p> <p>Chiropractic benefits with medical group referral only</p>	Not covered
Acupuncture/Acupressure	Not covered	
Maternity	<p>Office visits: \$25 copay</p> <p>Hospital Inpatient: \$250 per day copay up to the first four days, then covered at 100% per admission</p> <p>Outpatient Services: 20% of negotiated fee</p>	Not covered
Prescription Drugs 30-day supply retail; up to a 60-day supply available through mail order	<p>Blue Cross Formulary Drugs¹</p> <p>Generic: \$10 copay</p> <p>Brand-Name: \$30 copay after \$250 annual brand-name deductible (2-member maximum)²</p> <p>Self-Administered Injectables: 30% of negotiated fee, except insulin</p>	Copay as stated for In-Select HMO Network plus 50% of the Drug Limited Fee Schedule (DLFS) and all charges in excess of the DLFS.

¹ Non-Formulary Drugs: You pay 50% for generic and 100% for brand-name, up to brand-name deductible amount. After that you pay 50% for brand-name when no generic is available, or you pay the generic copay plus the difference in cost between a brand-name and available generic equivalent drug.

² If you select a brand-name drug when a generic equivalent drug is available, even if your physician writes a "dispense as written" or "do not substitute" prescription, you 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 your brand-name deductible.

Notes:

- This plan does not cover services by non-participating providers except for emergency services and prescription drugs.
- Generic drugs are based on the Blue Cross Drug Formulary.
- 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.

Exclusions and Limitations



What the Medical Plan Does Not Cover

Please take a few moments to review the exclusions and limitations. We want you to understand what your coverage includes – and what it does not include – before you enroll. These listings are an overview only. The Select HMO Combined Evidence of Coverage (EOC) and Disclosure Form contains a comprehensive list of the plan's exclusions and limitations. For a sample copy of an EOC, ask your agent or call Blue Cross at (800) 333-0912.

Exclusions and Limitations

- 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 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.
- 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 Copay/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.*

* 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.

- 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 this plan's prescription benefits.)
- 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.
- 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. This limitation does not apply to a child born or newly adopted by an enrolled subscriber, spouse, or Domestic Partner of the child(ren) of the enrolled Domestic Partner. 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.
- Services furnished through outdoor treatment programs.
- Consultations provided by telephone or fax.

- Educational services except as specifically provided or arranged by Blue Cross.
- Nutritional counseling and food supplements, except as stated in your plan 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.
- Care not authorized by your Primary Care Physician at your Participating Medical Group (PMG) or IPA.
- Growth hormone treatment.
- Amounts in excess of customary and reasonable charges for care rendered by a non-participating provider without a referral or authorization (excludes emergency services).
- Eyeglasses or contact lenses, unless specified in your plan agreement.
- Acupuncture/Acupressure.
- Chiropractic services, unless authorized by your medical group.
- Immunizations for foreign travel not specifically listed as covered.
- Treatment for chronic alcoholism or other substance abuse, unless specified in the plan agreement.
- Inpatient mental care, including acute alcoholism and drug addiction benefits, except detoxification.
- Treatment of mental and nervous disorders, except as stated in the plan agreement.
- Rehabilitative care, except as stated in the plan agreement.
- Private room, unless specified in the plan agreement.
- Reconstructive surgery, purchase or replacement of artificial limbs or prosthesis, unless the medical condition creating the need for the limb or prosthesis occurred while you were covered under the plan.
- 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 62 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 benefit details, please refer to the Evidence of Coverage 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
- Active natal labor (childbirth)
- Sudden weakness or numbness of the face, arm or leg on one side of the body

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 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 policy booklet along with a letter notifying us that you wish to discontinue coverage. Policy booklets are available for you to review prior to enrolling. Please ask your agent or Blue Cross for a copy.

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 (800) 333-0912.

Requirement 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.

Department of Managed Health Care

The California Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (800) 333-0912 and use your health plan's grievance process before contacting the department. Utilizing this grievance process does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the DMHC for assistance. 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 Web site (www.hmohelp.ca.gov) has grievance forms, IMR application forms and instructions.

Incurred Medical Care Ratio

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



Enrollment Guidelines



TO ENROLL, YOU 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, or the children of the applicant's enrolling spouse (or enrolling domestic partner), under 19 years of age; or
- the applicant's unmarried dependent children between the ages of 19 and 23 ("dependent" as defined by the Internal Revenue Service).

Medical Underwriting Requirement

We believe that the cost of covering someone whose health can be predicted to require costly care should not be subsidized by someone with minimal health care needs. That's why Blue Cross offers various levels of coverage, ensuring an overall balance of risk. To determine individual medical risk factors, all enrollments are subject to medical underwriting. Depending on the results of 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 alternative 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 Select HMO provider, and you remain eligible for membership. Coverage will cease if you become ineligible because of

- residency requirements and/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.



Security

Select HMO

Valuable Benefits. Predictable Costs.

Predictable

Coverage

Comprehensive

Easy to Understand

Reliable

Valuable

Ideal for Families



Medical Rating Area Definitions for Select HMO Network

The following indicates the counties and/or ZIP codes for each rating area.
The subscriber's home address determines the rating area.
These ZIP codes are specific to the Select HMO Network

Area 1: Not Available

Area 2: Fresno, Merced, Nevada (*except* ZIP codes 95728, 96111, 96160, 96161 & 96162), Placer (*except* ZIP codes 95715, 95724, 96140, 96141, 96142, 96143, 96145, 96146, 96148 & 96161), Sacramento, San Joaquin, San Mateo, Santa Clara (ZIP code 94303 only), Stanislaus

Area 3: Alameda, Contra Costa, San Francisco, Santa Clara (*except* ZIP code 94303), Santa Cruz, Yolo

Area 4: Orange, Riverside (*only* ZIP code 92883)

Area 5: Los Angeles (*except* ZIP codes beginning with 906-912, 915, 917-918 & 935),

Area 6: Imperial, Riverside (*except* ZIP codes 92883, 92225, 92226, 92239), San Bernardino (*except* zip codes 92363, 92364, 92365), San Diego (*except* ZIP codes 91901, 91905, 91906, 91916, 91917, 91934, 91935, 91948, 91962, 91963, 91980, 92004, 92036, 92059, 92061, 92066 & 92086)

Area 7: Kern, Tulare

Area 8: Not Available

Area 9: Los Angeles (*only* ZIP codes beginning with 906-912, 915, 917, 918 & 935)



Monthly Individual Select HMO (PE43)

Monthly Rates Effective October 1, 2004

Level 1	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Area 9
Single									
19-29	N/A	\$216.00	\$177.00	\$137.00	\$139.00	\$154.00	\$154.00	N/A	\$129.00
30-34	N/A	\$272.00	\$226.00	\$162.00	\$165.00	\$198.00	\$191.00	N/A	\$152.00
35-39	N/A	\$307.00	\$262.00	\$177.00	\$179.00	\$220.00	\$209.00	N/A	\$166.00
40-44	N/A	\$325.00	\$293.00	\$186.00	\$189.00	\$233.00	\$220.00	N/A	\$174.00
45-49	N/A	\$371.00	\$314.00	\$212.00	\$215.00	\$265.00	\$250.00	N/A	\$198.00
50-54	N/A	\$395.00	\$325.00	\$239.00	\$243.00	\$282.00	\$282.00	N/A	\$223.00
55-59	N/A	\$433.00	\$358.00	\$252.00	\$256.00	\$312.00	\$299.00	N/A	\$235.00
60-64	N/A	\$580.00	\$532.00	\$326.00	\$331.00	\$411.00	\$388.00	N/A	\$304.00
Subscriber & Spouse									
Under 30	N/A	\$486.00	\$401.00	\$297.00	\$302.00	\$350.00	\$343.00	N/A	\$279.00
30-34	N/A	\$577.00	\$486.00	\$337.00	\$342.00	\$416.00	\$398.00	N/A	\$316.00
35-39	N/A	\$630.00	\$553.00	\$361.00	\$366.00	\$451.00	\$427.00	N/A	\$338.00
40-44	N/A	\$694.00	\$605.00	\$396.00	\$402.00	\$496.00	\$468.00	N/A	\$370.00
45-49	N/A	\$764.00	\$637.00	\$449.00	\$456.00	\$545.00	\$530.00	N/A	\$419.00
50-54	N/A	\$826.00	\$681.00	\$489.00	\$497.00	\$592.00	\$579.00	N/A	\$456.00
55-59	N/A	\$1,011.00	\$888.00	\$576.00	\$585.00	\$721.00	\$685.00	N/A	\$537.00
60-64	N/A	\$1,158.00	\$1,062.00	\$650.00	\$660.00	\$820.00	\$774.00	N/A	\$606.00
Subscriber & Child									
Under 30	N/A	\$407.00	\$359.00	\$256.00	\$260.00	\$299.00	\$292.00	N/A	\$242.00
30-34	N/A	\$463.00	\$408.00	\$281.00	\$286.00	\$343.00	\$329.00	N/A	\$265.00
35-39	N/A	\$498.00	\$442.00	\$296.00	\$300.00	\$365.00	\$347.00	N/A	\$279.00
40-44	N/A	\$506.00	\$443.00	\$302.00	\$307.00	\$368.00	\$355.00	N/A	\$284.00
45-49	N/A	\$513.00	\$443.00	\$309.00	\$313.00	\$372.00	\$362.00	N/A	\$290.00
50-54	N/A	\$521.00	\$444.00	\$315.00	\$320.00	\$375.00	\$370.00	N/A	\$295.00
55-59	N/A	\$559.00	\$475.00	\$328.00	\$333.00	\$405.00	\$387.00	N/A	\$307.00
60-64	N/A	\$706.00	\$649.00	\$402.00	\$408.00	\$504.00	\$476.00	N/A	\$376.00
Family									
Under 30	N/A	\$678.00	\$584.00	\$417.00	\$424.00	\$496.00	\$482.00	N/A	\$393.00
30-34	N/A	\$769.00	\$669.00	\$457.00	\$464.00	\$562.00	\$537.00	N/A	\$430.00
35-39	N/A	\$822.00	\$736.00	\$481.00	\$488.00	\$597.00	\$566.00	N/A	\$452.00
40-44	N/A	\$857.00	\$746.00	\$504.00	\$511.00	\$618.00	\$593.00	N/A	\$472.00
45-49	N/A	\$891.00	\$755.00	\$526.00	\$534.00	\$639.00	\$619.00	N/A	\$492.00
50-54	N/A	\$953.00	\$799.00	\$566.00	\$575.00	\$686.00	\$668.00	N/A	\$529.00
55-59	N/A	\$1,138.00	\$1,006.00	\$653.00	\$663.00	\$815.00	\$774.00	N/A	\$610.00
60-64	N/A	\$1,285.00	\$1,180.00	\$727.00	\$738.00	\$914.00	\$863.00	N/A	\$679.00
Subscriber & Children									
Under 30	N/A	\$534.00	\$477.00	\$333.00	\$338.00	\$393.00	\$381.00	N/A	\$315.00
30-34	N/A	\$590.00	\$526.00	\$358.00	\$364.00	\$437.00	\$418.00	N/A	\$338.00
35-39	N/A	\$625.00	\$560.00	\$373.00	\$378.00	\$459.00	\$436.00	N/A	\$352.00
40-44	N/A	\$633.00	\$561.00	\$379.00	\$385.00	\$462.00	\$444.00	N/A	\$357.00
45-49	N/A	\$640.00	\$561.00	\$386.00	\$391.00	\$466.00	\$451.00	N/A	\$363.00
50-54	N/A	\$648.00	\$562.00	\$392.00	\$398.00	\$469.00	\$459.00	N/A	\$368.00
55-59	N/A	\$686.00	\$593.00	\$405.00	\$411.00	\$499.00	\$476.00	N/A	\$380.00
60-64	N/A	\$833.00	\$767.00	\$479.00	\$486.00	\$598.00	\$565.00	N/A	\$449.00
Single Child									
0	N/A	\$193.00	\$184.00	\$121.00	\$123.00	\$147.00	\$140.00	N/A	\$115.00
1-18	N/A	\$128.00	\$119.00	\$78.00	\$79.00	\$95.00	\$90.00	N/A	\$74.00
2 Children									
0	N/A	\$384.00	\$366.00	\$240.00	\$244.00	\$292.00	\$278.00	N/A	\$228.00
1-18	N/A	\$319.00	\$301.00	\$197.00	\$200.00	\$240.00	\$228.00	N/A	\$187.00
3 Children									
0	N/A	\$576.00	\$549.00	\$360.00	\$366.00	\$438.00	\$417.00	N/A	\$342.00
1-18	N/A	\$446.00	\$419.00	\$274.00	\$278.00	\$334.00	\$317.00	N/A	\$260.00

The rates above are Level 1 (standard) rates. Rates may be higher based on your underwriting review. The Select HMO plan is not available in Area 1 and Area 8.

Note:

For the **Subscriber & Spouse** and **Family** categories, rates are based on the age of the younger spouse (or younger domestic partner). In some cases, purchasing separate policies for each member may reduce the premium.

For children-only contracts, rates are based on the age of the youngest child (and the youngest child will be assigned as the subscriber).



BlueCross
of California

This is only an overview of coverage. A comprehensive description of coverage, benefits and limitations is contained in the Evidence of Coverage (EOC). Review the Exclusions and Limitations listed in the EOC prior to applying for coverage. For a copy, contact your agent or call Blue Cross of California at 800-333-0912.

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