

PPO Summary of Benefits

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE *EVIDENCE OF COVERAGE* AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

PPO Mix and Match Guidelines	Total Group Size	Plans Available		
	2-4 medically enrolled employees	All HMO and HMO Value; PPO 1000 and PPO 2400; HSA 1500 and HSA 2400		
	5+ medically enrolled employees	All HMO and HMO Value; Refer to Employee enrollment worksheet for PPO availability.		
Deductible, Copay and Out-of-Pocket Maximum		CalChoice® PPO 750	CalChoice® PPO 1000	CalChoice® PPO 2400
Deductibles¹ (Deductibles do not apply to the calendar year copay maximum)				
■ Individual		\$ 750	\$ 1,000	\$ 2,400
■ Family		\$ 2,250	\$ 3,000	\$ 7,200
Copays				
Physician Office Visit Copay				
■ Per visit		\$ 35	\$ 35	\$ 40
Calendar Year Copay Maximum				
In-Network Providers				
■ Individual		\$ 3,750	\$ 4,000	\$ 5,000
■ Family		\$ 7,500	\$ 8,000	\$ 10,000
Out-of-Network Providers				
■ Individual		\$ 10,000	\$ 10,000	\$ 10,000
■ Family		\$ 20,000	\$ 20,000	\$ 20,000
Lifetime Maximum		\$ 6,000,000	\$ 6,000,000	\$ 6,000,000

Benefits	CalChoice® PPO 750		CalChoice® PPO 1000		CalChoice® PPO 2400	
	In Network ²	Out of Network ²	In Network ²	Out of Network ²	In Network ²	Out of Network ²
Physician Services — Outpatient						
PCP or OB Office Visit	\$ 35 Copay	50% ¹	\$ 35 Copay	50% ¹	\$ 40 Copay	50% ¹
Specialist Office Visit	\$ 35 Copay	50% ¹	\$ 35 Copay	50% ¹	\$ 40 Copay	50% ¹
Mammogram and PAP Test	\$ 35 Copay	50%	\$ 35 Copay	50%	\$ 40 Copay	50% ¹
Laboratory, X-Ray & Diagnostic (<i>Deductible Applies</i>)	\$ 35 Copay	50% ³	\$ 35 Copay	50% ³	70%	50% ³ (max. \$ 600/visit)
Physician Services — Inpatient						
Inpatient visits and consultations	80%	50% ³	70%	50% ³	70%	50% ³
Surgeons, assistants, anesthesiologists, pathologists, radiologists	80%	50% ³	70%	50% ³	70%	50% ³
Preventive Benefits (<i>Not subject to cal. yr. deductible</i>)						
Annual Physical Exam (<i>Including eye/ear screening, immunizations up to age 17</i>)	\$ 35 Copay	Not Covered	\$ 35 Copay	Not Covered	\$ 40 Copay	Not Covered
Mammogram and Pap Test	\$ 35 Copay	Not Covered	\$ 35 Copay	Not Covered	\$ 40 Copay	Not Covered
Laboratory	\$ 35 Copay	Not Covered	\$ 35 Copay	Not Covered	\$ 40 Copay	Not Covered
Hospital Services — Outpatient						
Outpatient surgery	\$ 500 copay ¹ then: 80%	50% ³ (to \$ 600 a day)	\$ 500 copay ¹ then: 70%	50% ³ (to \$ 600 a day)	\$ 500 copay then: 70%	50% ³ (to \$ 600 a day)
Hospital Services — Inpatient						
Room, Board, Service and Supplies <i>Skilled Nursing Facility In Hospital Max. 100 Days PPO 750 & 1000 Max. 60 Days PPO 2400</i>	\$ 500 copay then: 80%	50% ³ (to \$ 600 a day)	\$ 1,000 Ded. then: 70%	50% ³ (to \$ 600 a day)	\$ 500 copay then: 70%	50% ³ (to \$ 600 a day)

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Benefits, con't	CalChoice® PPO 750		CalChoice® PPO 1000		CalChoice® PPO 2400	
	In Network ²	Out of Network ²	In Network ²	Out of Network ²	In Network ²	Out of Network ²
Pregnancy & Maternity Care						
Prenatal and postnatal care	80%	50%	70%	50%	70%	50%
All necessary inpatient hospital services	Covered Under Inpatient Hospital					
Emergency Services						
ER Facility Resulting In Immediate Admission	Covered Under Inpatient Hospital					
ER Facility Not Resulting In Admission	\$ 150 Copay ¹	\$ 150 Copay ¹	\$ 150 Copay ¹	\$ 150 Copay ¹	\$ 150 Copay ¹	\$ 150 Copay ¹
ER Physician Services (Not Resulting In Admission)	then 80%	then 80%	then 70%	then 70%	then 70%	then 70%
Ambulance	50%	50%	70%	70%	70%	70%
Home Medical Equipment	50%	50%	50% of allowable amnt. max 2k per yr.	50% of allowable amnt. max 2k per yr.	50% of allowable amnt. max 2k per yr.	Not covered
Psychiatric - Severe (AB 88 Requirement on Page 17)						
Outpatient	\$ 35 Copay	50% ¹	\$ 35 Copay	50% ¹	\$ 40 Copay	50% ¹
Inpatient	\$ 500 Copay then 80%	50% ³ (to \$ 600 a day)	\$ 1,000 Deductible then 70%	50% ³ (to \$ 600 a day)	\$ 500 Deductible then 70%	50% ³
Psychiatric - Non Severe Includes Alcohol/Substance Abuse Care						
Outpatient (Maximum of 20 visits per calendar year)	50%	Not Covered	50%	Not Covered	50%	Not Covered
Inpatient (medical acute detoxification only)	Covered Under Inpatient Hospital					
Hospice - Routine Home Care	100% if authorized	100% if authorized or not covered	100% if authorized	100% if authorized or not covered	100% if authorized	100% if authorized or not covered
24-Hour Continuous Care	80% if authorized	80% if authorized or not covered	70% if authorized	70% if authorized or not covered	70% if authorized	70% if authorized or not covered
Chiropractic - Max. 12 Visits (Deductible Applies)	80%	50%	70%	50%	70% ⁴	50% ⁴
Acupuncture	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered

Prescription Costs	Participating Pharmacy		Non-Participating Pharmacy	Non-Participating Pharmacy	Mail Service Prescriptions
	PPO 750**/1000***/2400****	PPO 750**/1000****	PPO 750**/1000****	PPO 2400****	PPO 750**/1000***/2400****
Outpatient Prescription Drugs¹ (Not subject to deductible, includes oral contraceptives)	Prescription Costs		Up to 30 day supply Member pays 25% plus	Not Covered	For up to a 90 day supply
Generic Drugs	\$ 15		\$ 15		\$ 30
Formulary Brand Drugs	\$ 30		\$ 30		\$ 60
Non-Formulary Brand Drugs	\$ 50		\$ 50		\$ 100

** A separate \$ 150 per individual deductible applies to formulary and non-formulary brand drugs.
 *** A separate \$ 200 per individual deductible applies to formulary and non-formulary brand drugs.
 **** A separate \$ 250 per individual deductible applies to formulary and non-formulary brand drugs.

Note: All PPO plans exclude coverage for pre-existing conditions (except for pregnancy) for the first six months of coverage unless replacing prior creditable coverage (see Evidence of Coverage for complete explanation).

1 Copays for services do NOT count toward the copay maximum and continue to be charged after it is reached.

2 Preferred Providers accept Blue Shield's allowable amount as full payment for covered services. Non-Preferred Providers can charge more than these amounts. When members use Non-Preferred Providers, they must pay the applicable copay plus any amount that exceeds Blue Shield's allowable amount. Charges in excess of the allowable amount do not count toward the calendar year deductible or copay maximum.

3 The maximum allowed charge for non-emergency hospital services received from a Non-Preferred Hospital is \$600 per day. Members are responsible for 50% of this \$600 per day, plus all charges in excess of \$600. Physician Services are covered separately at 50% of allowable amounts.

4 Visits are combined between PT, OT, Speech, Chiro Services and Respiratory visits.