

Carrier Name: Blue Cross of California
Plan Names: Blue Cross Plus (Indemnity) Plan
Blue Cross Classic (PPO) Plan

The Blue Cross Plus (Indemnity) and Classic (PPO) Plans provide you and your family access to medical care from ANY licensed physician, hospital, or other provider.

You are able to access the highest level of benefits at the lowest out-of-pocket cost to you, when you choose a Blue Cross provider. These providers have contracts with Blue Cross and have agreed to provide their services for a pre-negotiated, discounted fee.

When you need care, you may choose a Blue Cross provider or non-Blue Cross provider. It's your choice. The level of benefits available to you will differ based on your choice of provider and your choice of plan. To obtain a directory of Blue Cross providers, call Blue Cross at (800) 759-3030; or visit the Blue Cross website at: www.bluecrossca.com

Blue Cross Plus (Indemnity) Plan

This plan is an indemnity medical plan with basic and major medical benefit provisions. As you will see in the Summary of Benefits, most care is covered at 80% to 100%, after satisfying any applicable deductible or copayment.

When you choose a Blue Cross provider, the benefits will be paid based on the pre-negotiated, discounted fee. You are NOT responsible for any amount over that fee. If you choose to obtain health care services from a non-Blue Cross provider, the payment of benefits is based on what is customary and reasonable for the same service in your area. You are responsible for the difference.

Blue Cross Classic (PPO) Plan

As you will see in the Summary of Benefits, most care is provided at 100%, with no deductible. Some services will require a small copayment.

When you choose a Blue Cross provider, the payment of benefits will be based on the pre-negotiated discounted fee. You are NOT responsible for any amount over that fee. If you choose to obtain health care services from a non-Blue Cross provider, the benefits will be paid according to a reduced fee schedule. You will be responsible for the difference.

How to File a Claim

If you go to a Blue Cross provider, the claim will be filed for you and Blue Cross will reimburse the provider directly. If you go to a non-Blue Cross provider, you may be required to pay the bill in full and then submit the claim to Blue Cross at:

P.O. Box 60007 - Los Angeles, CA 90060-0007

BLUE CROSS PLANS:

Summary of Benefits

	<i>Blue Cross Plus (Indemnity) Plan</i>	<i>Blue Cross Classic (PPO) Plan</i>
DEDUCTIBLES (Calendar Year)		
Per Individual	Basic: None Major: \$100 (waived if PPO hospitalized)	None
Per Family	Basic: None Major: \$300 (waived if PPO hospitalized)	None
OUT-OF-POCKET MAXIMUM (Calendar Year)		
Per Individual	Basic: None Major: \$1,000	None
Per Family	Basic: None Major: \$1,000/member	None
LIFETIME MAXIMUMS		
Lifetime Maximums	\$2,000,000	\$2,000,000
PROFESIONAL SERVICES		
Physician Services		
Office visits and consultations	100% after \$10 copay	100% after \$10 copay
Specialist office visits and consultations	100% after \$10 copay	100% after \$10 copay
Laboratory, X-rays and diagnostics	80%	100%
PREVENTIVE CARE (age 7 and over)		
Annual routine physical exam office visit; Laboratory, X-rays, diagnostics, immunizations and vaccinations	PPO: \$25 copay, up to \$250 per year Non-PPO: Not covered	100% to \$200 per year
Annual pap test (<i>laboratory work</i>)	80%	100%
Mammography screening	80%	100%
OUTPATIENT SERVICES		
Outpatient surgery/treatment	100%	100%
Renal Dialysis	100%	100%
HOSPITALIZATION SERVICES		
Inpatient Services – Non-Emergency		
Inpatient visits and consultations	100%	100%
Surgeons and assistants, anesthesiologists, pathologists, radiologists	100%	100%
Semi-private room and board, medically necessary services and supplies, including subacute care	100%	100%
EMERGENCY HEALTH COVERAGE		
Emergency Health Coverage	100%	100%
AMBULANCE SERVICES		
Ambulance Services	100% to \$50/trip then 80% of the balance	100%
DURABLE MEDICAL EQUIPMENT		
Prosthetic appliances and home medical equipment	80%	100%

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MENTAL HEALTH SERVICES (PSYCHIATRIC)		
Inpatient mental health conditions	100%	80%
Outpatient mental health conditions	50% to \$10 per visit	50% to \$50 per visit (PPO) and \$25 per visit (non-PPO)
The above copayments and maximums do not apply to severe mental health conditions which are subject to the same copayments and maximums as any other covered service		
CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)		
Inpatient medical acute detoxification	100%	80%
Outpatient visits (<i>up to 50 visits per calendar year combined with non-severe mental health visits</i>)	50% to \$10 per visit	50% to \$50 per visit (PPO) and \$25 per visit (non-PPO)
WELL-BABY CARE		
Well-baby care (<i>birth until age 7</i>)	PPO: 100% after \$25 copay, Non-PPO: 80% up to \$20 max payment	100%
Immunizations	PPO: 100% after \$25 copay Non-PPO: 80% up to \$12 max payment	100%
FAMILY PLANNING		
Family planning counseling	80%	100%
Elective abortion	80%	100%
Tubal ligation, vasectomy	80%	100%
PHYSICAL MEDICINE		
Office visits and related services, such as physical therapy and occupational therapy	80%	100%
OTHER		
Acupuncture Services	80%	100%
Chiropractic	80%	Not covered
Skilled Nursing Facility (SNF) Services		
Semi-private accommodations in a freestanding SNF (for hospital SNF unit, see "Hospitalization Services")	100%	100%, up to 100 days per year
Diabetes Care		
Equipment, devices and supplies	80%	100%
Self-management training and education	100% after deductible	100%
Hearing Aids (<i>maximum per 3 year period</i>)	80% to \$500	80% to \$500
Prescription Drugs		
Retail (30 day supply)	\$5 generic and \$15 brand	\$5 generic and \$15 brand
Mail Order (90 day supply)	\$5 generic and \$15 brand	\$5 generic and \$15 brand

BLUE CROSS PLANS:

Limitations & Exclusions

The following is a summary of some of the services that are not covered by Blue Cross of California. Please consult your individual summary plan description for a complete list of exclusions and coverage limitations.

- ◆ Not medically necessary services.
- ◆ Experimental or Investigative procedures.
- ◆ Work related conditions.
- ◆ Services of relatives.
- ◆ Inpatient diagnostic tests.
- ◆ Dental services or supplies (other than for dental injury or jaw joint disorders).
- ◆ Optometric services or supplies.
- ◆ Obesity (other than for morbid obesity, as determined by Blue Cross).
- ◆ Sex transformation.
- ◆ Sterilization reversal.
- ◆ Infertility treatment.
- ◆ Orthopedic supplies (other than for shoes joined to braces or therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications).
- ◆ Air conditioners.
- ◆ Custodial care or rest cures.
- ◆ Exercise equipment.
- ◆ Telephone and facsimile machine consultations.
- ◆ Eye surgery for refractive defects.
- ◆ Lifestyle programs.

This Summary of Benefits and Limitations and Exclusions are intended to highlight your benefits only. For more detailed information about the benefits and exclusions and limitations, please refer to the individual Summary Plan Description.