Individual and Family Plans

Sales and Enrollment Guide Companion Brochure

BlueCross
of California

PLANSCAPE: OVERVIEW OF COVERAGE *. . . and member's share of costs (after deductible, if ar*

This is an overview of coverage. A comprehensive description of coverage, benefits, and limitations is contained in the Combined Evidence of Coverage and Disclosure Form. For a copy, contact us or your agent.

Note:
Benefits for cancer clinical trials in accordance with Health and Safety Code Section 1370.6 will be available administratively.

[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] Participating provider discounts apply to covered services **before** and **after** the deductible is met.
[3] Additional $500 admission charge at Participating Hospitals (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.
[4] Additional $30 copay for PPO Plans applies for each emergency room visit (waived if admitted as inpatient).
[5] Tests ordered by a physician are covered.
[6] Benefits include visits to participating and non-participating providers combined.
[7] Generic drugs are based upon the Blue Cross drug formulary.
[8] Brand-name drug deductible does not apply to out-of-pocket maximum.
[9] Self-administered injectables except insulin are not available through mail order.
[10] Members covered more than six (6) months, up to $200. Members covered less than six (6) months, up to $100. Limited to one (1) visit per calendar year

HMO Notes:
- These plans do not cover services by non-participating providers except for emergency services and prescription drug benefits.
- The HMO Saver Plan deductible pertains to non-emergency inpatient and outpatient facility charges and Ambulatory Surgical Centers (does not include professional services).
- For emergency services, the service area is a 20-mile radius from your participating medical group.
- The $50 copay for emergency room services applies to each emergency room visit and is waived if admitted as inpatient.
- 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.

Benefits	Basic PPO 1000 * (7900) *BC Life & Health*		PPO Share 5000 (H062) *BC Life & Health*	
	Participating Provider	Non-Participating Provider	Participating Provider	Non-Participating Provider
Lifetime Maximum	$5,000,000/member		$5,000,000/member	
Annual Out-of-Pocket Maximum *(includes deductible)*	$3,500/single, only hospital costs apply (2-member maximum); participating and non-participating combined[1]		$7,500/single (2-member maximum); participating and non-participating combined[1]	
Annual Deductible *(applies to above maximum)*	$1,000/single, inpatient or surgical procedures only (2-member maximum); all covered benefits		$5,000/single (2-member maximum)	
Office Visits	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	30% of negotiated fee for office visits *(deductible waived)*	50% of negotiated fee plus excess *(deductible waived)*
Professional Services *(x-ray, lab, anesthesia, surgeon, etc.)*	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 services	30% of negotiated fee	50% of negotiated fee plus excess for covered services
Hospital Inpatient/ Outpatient	20% of negotiated fee[3]	All charges except $650/day inpatient, $380/day outpatient	30% of negotiated fee[3]	All charges except $650/day inpatient, $380/day outpatient
Emergency Services	20% of negotiated fee[4]	20% 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	Not covered	Not covered	30% of negotiated fee	50% of negotiated fee plus 100% of excess
Preventive Care	Routine mammogram, PSA, and Pap tests[5]: 20% of negotiated fee *(deductible waived)* *HealthyCheck Centers:* $25 or $75 copay for basic screenings	Routine mammogram, PSA, and Pap tests[5]: 50% of negotiated fee plus excess *(deductible waived)*	Routine mammogram, PSA, and Pap tests[5]: 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, PSA, and Pap tests[5]: 50% of negotiated fee plus excess *(deductible waived)* Well Child: 50% of negotiated fee through age 6 *(deductible waived)*
Ambulance	20% of negotiated fee plus excess of the $750 maximum per ground trip	50% of negotiated fee plus excess of negotiated fee and in excess of the $750 maximum per ground trip	30% of negotiated fee	50% of negotiated fee plus excess
Physical and Occupational Therapy; Chiropractic Services	Not covered unless during inpatient admission	Not covered unless during inpatient admission	30% of negotiated fee, up to 12 visits/year[6]	All charges except $25 per visit, up to 12 visits/year[6]
Acupuncture/ Acupressure	Not covered	Not covered	All charges except $25/visit, up to 24 visits/year[6] *(deductible waived)*	All charges except $25/visit, up to 24 visits/year[6] *(deductible waived)*
Drug Benefits *retail or mail order[9]: 30-day supply*	Not covered	Not covered	$10 generic[7]; $35 brand-name copay ***after*** $750 brand-name deductible[8] (2-member maximum**); 30% of negotiated fee for self-administered injectables, except insulin	50% generic[7] or 50% of brand-name Drug Limited Fee Schedule within California; $750 brand-name deductible**

* *Designed to cover Hospital and other limited expenses for catastrophic illness and injury* ** *If a member selects a brand-name drug when a generic e*

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PPO Saver (NM31) *BC Life & Health*		PPO Share 2500 (7891)		PPO Share 1500/1000/500 (7889, 1393/1930***, 7895/1929***)	
Participating Provider	**Non-Participating Provider**	**Participating Provider**	**Non-Participating Provider**	**Participating Provider**	**Non-Participating Provider**
$5,000,000/member		$5,000,000/member		$5,000,000/member	
$5,000/single (2-member maximum); participating and non-participating combined[1]		$5,000/single (2-member maximum); participating and non-participating combined[1]		$4,000/single (2-member maximum) Participating and non-participating combined[1]	
$500 inpatient or surgical procedures only, $5,000 other covered services (2-member maximum)[2] All covered benefits		$2,500/single (2-member maximum); all covered benefits		$1,500/$1,000/$500 member (2-member maximum) All covered benefits	
Children: 4 office visits per year at $30 copay/visit; Adults: 2 office visits per year at $30 copay/visit *(deductible waived)*	Children: 4 office visits per year; Adults: 2 office visits per year; 50% of negotiated fee plus excess *(deductible waived)*	30% of negotiated fee *(deductible waived)*	50% of negotiated fee plus excess *(deductible waived)*	30% of negotiated fee *(deductible waived)*	50% of negotiated fee *(deductible waived)*
20% of negotiated fee for inpatient or surgical procedures only. No other covered services until out-of-pocket maximum is met, then covered at 100% of negotiated fee	50% of negotiated fee plus excess for inpatient or surgical procedures only. No other covered services until out-of-pocket maximum is met	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
20% of negotiated fee[3] after $500 deductible	All charges except $650/day inpatient, $380/day outpatient	30% of negotiated fee[3]	All charges except $650/day inpatient, $380/day outpatient	30% of negotiated fee[3]	All charges except $650/day inpatient, $380/day outpatient
20% of negotiated fee[4] after $500 deductible is met	20% 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 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]
Not covered	Not covered	30% of negotiated fee	50% of negotiated fee plus 100% of excess	30% of negotiated fee	50% of negotiated fee plus 100% of excess
Routine mammogram, PSA, and Pap tests[5]: 20% of negotiated fee *(deductible waived)* Well Child: 50% of negotiated fee through age 6 *(deductible waived)* *HealthyCheck Centers:* $25 or $75 copay for basic screenings	Routine mammogram, PSA, and Pap tests[5]: 50% of negotiated fee plus excess *(deductible waived)* Well Child: 50% of negotiated fee through age 6 plus charges in excess of negotiated fee *(deductible waived)*	Routine mammogram, PSA, and Pap tests[5]: 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, PSA, and Pap tests[5]: 50% of negotiated fee plus excess *(deductible waived)* Well Child: 50% of negotiated fee through age 6 *(deductible waived)*	Routine mammogram, PSA, and Pap tests[5]: 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 PPO Share 500 and PPO Share 1000 only: Annual Physical Exam[10]: 30% negotiated fee *(deductible waived)*	Routine mammogram, PSA, and Pap tests[5]: 50% of negotiated fee plus excess *(deductible waived)* Well Child: 50% of negotiated fee through age 6 *(deductible waived)* PPO Share 500 and PPO Share 1000 only: Annual Physical Exam[10]: 50% negotiated fee plus excess for covered services *(deductible waived)*
20% of negotiated fee plus excess of the $750 maximum per ground trip	50% of negotiated fee plus excess of negotiated fee and in excess of the $750 maximum per ground trip	30% of negotiated fee	50% of negotiated fee plus excess	30% of negotiated fee	50% of negotiated fee plus excess
20% of negotiated fee, up to 12 visits/year[6]	All charges except $25/visit, up to 12 visits/year[6]	30% of negotiated fee, up to 12 visits/year[6]	All charges except $25 per visit, up to 12 visits/year[6]	30% of negotiated fee, up to 12 visits/year[6]	All charges except $25/visit, up to 12 visits/year[6]
All charges except $25/visit, up to 24 visits/year[6]	All charges except $25/visit, up to 24 visits/year[6]	All charges except $25/visit, up to 24 visits/year[6] *(deductible waived)*	All charges except $25/visit, up to 24 visits/year[6] *(deductible waived)*	All charges except $25/visit, up to 24 visits/year[6] *(deductible waived)*	All charges except $25/visit, up to 24 visits/year[6] *(deductible waived)*
$10 generic[7]; $30 brand-name copay ***after*** $500 brand-name deductible[8] (2-member maximum**); 30% of negotiated fee for self-administered injectables, except insulin	50% generic[7] or 50% of brand-name Drug Limited Fee Schedule within California; $500 brand-name deductible**	$10 generic[7]; $30 brand-name copay ***after*** $500 brand-name deductible[8] (2-member maximum**); 30% of negotiated fee for self-administered injectables, except insulin	50% generic[7] or 50% of brand-name Drug Limited Fee Schedule within California; $500 brand-name deductible**	$10 generic[7]; $30 brand-name copay ***after*** $250 brand-name deductible[8] (2-member maximum**); 30% of negotiated fee for self-administered injectables, except insulin	50% generic[7] or 50% of brand-name Drug Limited Fee Schedule within California; $250 brand-name deductible**

valent 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 br

HMO OVERVIEW *. . . and member's share of cost (after deductible, if any)*

HMO Saver (7896) *(available state wide)*	**Individual HMO (7898)** *(available state wide)*
Unlimited	Unlimited
$3,000/single (2-member maximum)	$3,000/single (2-member maximum)
$1,500/member; inpatient hospital services, outpatient Ambulatory Surgical Centers	No deductible
You pay $10	You pay $10
Unlimited office visits: You pay $10 per visit; Inpatient Hospital: no charge	Unlimited office visits: You pay $10 per visit; Inpatient Hospital: no charge
Subject to $1,500 deductible, Inpatient: no charge; Outpatient: You pay 20% of negotiated fee (for non-emergency services)	Inpatient: no charge; Outpatient: You pay 20% of negotiated fee (for non-emergency services)
Inpatient and professional services: no charge when authorized by your medical group within 48 hours of emergency care; Outpatient: You pay $50 emergency room copay plus 20% of negotiated fee	
Office visits, inpatient and outpatient paid as above (inpatient and outpatient subject to deductible)	Office visits, inpatient and outpatient paid as above
You pay a $10 copay for specific health maintenance services	You pay a $10 copay for specific health maintenance services
You pay a $50 copay unless admitted to the hospital	You pay a $50 copay unless admitted to the hospital
You pay $10 per visit; limited to 60 consecutive days following illness or injury; no charge for inpatient services; chiropractic benefits with medical group referral	You pay $10 per visit; limited to 60 consecutive days following illness or injury; no charge for inpatient services; chiropractic benefits with medical group referral
Not Covered	Not Covered
Participating Provider $10 generic; $30 brand-name copay ***after*** $250 brand-name deductible (2-member maximum**); 30% of negotiated fee for self-administered injectables, except insulin *Non-Participating Provider* $250 brand-name deductible, then 50% of Drug Limited Fee Schedule within California**	*Participating Provider* $10 generic; $30 brand-name copay ***after*** $250 brand-name deductible (2-member maximum**); 30% of negotiated fee for self-administered injectables, except insulin *Non-Participating Provider* $250 brand-name deductible, then 50% of Drug Limited Fee Schedule within California**

d-name drug and the generic equivalent drug. The amount paid does not apply to the member's brand-name deductible. *** *Plans offered through BC Life & Health*

WHAT THE MEDICAL PLANS DO NOT COVER

Every health plan has exclusions and limitations that describe what the plans do not cover. General exclusions and limitations for the health plans described in this brochure are listed here.

Please take a few moments to review these listings. We want you to understand what your coverage does not include before you enroll.

These listings are an overview only. Plan-specific Evidence of Coverage booklets contain a comprehensive list of each plan's exclusions and limitations. For a sample copy of an Evidence of Coverage booklet, ask your agent or contact us.

Exclusions and Limitations Common to All Individual Medical Plans

- 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 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) except as specifically stated for PPO Share 500/1000 plans.
- 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 all plans' prescription benefits except the Basic Plan).
- 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 or spouse. Also, if you were covered under qualifying prior coverage within 63 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.
- 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.

WHAT THE MEDICAL PLANS DO NOT COVER

- Outpatient speech therapy, except following surgery, injury or otherwise as medically necessary.
- Benefits for Hospice services are limited to a lifetime maximum of $10,000 per member for participating and non-participating providers combined (BC Life PPO Share 500, BC Life PPO Share 1000, BC Life PPO Share 5000, PPO Saver, PPO Basic only).

Additional Exclusions and Limitations for Basic PPO Only

- 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.
- Eye glasses and eye examinations.

Additional Exclusions and Limitations for PPO Saver Only

- Maternity care.

Additional Exclusions and Limitations for HMO Plans Only

- 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.
- 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.

All medical plans, except the Basic PPO 1000, PPO Saver, BC Life PPO Share 5000, BC Life PPO Share 1000 and BC Life PPO Share 500, are offered by Blue Cross of California. The Basic PPO 1000, PPO Saver, BC Life PPO Share 5000, BC Life PPO Share 1000, and BC Life PPO Share 500 products are offered by BC Life & Health Insurance Company.

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