



Blue Cross CaliforniaCare HMO

Policy Numbers: 59Q90A & L, 56AYKA & B and 59Q90B

Eligibility

Eligible dependents include your legally married spouse, domestic partner and unmarried child(ren) up to age 19, or up to age 25 if full-time students at an accredited institution. Child(ren) must be dependent upon the employee for financial support, unless there is a court order specifying that the employee carry health insurance, and the employee can claim the dependent for federal income tax purposes. Child(ren) are defined as: natural, stepchild(ren), adopted child(ren), and child(ren) or grandchild(ren) that the employee or the employee's spouse have been appointed legal guardian ship for by a court of law. Mentally or physically challenged child(ren) over the limiting age are covered as long as they are dependent on the employee for support, and they do not have self-sustaining employment.

Newly hired eligible employees who enroll within 31 days of eligibility for coverage will be covered on the 1st or 16th of the month following date of hire.

In the case of status changes made within 31 days of the event, the effective date of coverage will be effective the date of the status change.

Termination of Coverage

Coverage ends the 15th or end of the month following retirement or termination.

Primary Care Physician

Blue Cross HMO benefits are covered only when services are provided or coordinated by the primary care physician and authorized by the participating medical group or independent practice association (IPA), except services provided under the "Ready Access" program, OB/GYN services received within the member's medical group/IPA, and services for all mental and nervous disorders.

2007 Premium Rates

Below is the monthly premium for HMO coverage:

Full-Time Employee (32+ Hours/week)

	Employee	Employer	Total
Employee Only	\$48.00	\$440.00	\$488.00
Employee+ Spouse	\$194.00	\$782.00	\$976.00
Employee + Child(ren)	\$158.00	\$697.00	\$855.00
Family	\$341.00	\$1,124.00	\$1,465.00

Part-Time Employee (20 - 31Hours/week)

	Employee	Employer	Total
Employee Only	\$268.00	\$220.00	\$488.00
Employee+ Spouse	\$585.00	\$391.00	\$976.00
Employee + Child(ren)	\$506.50	\$348.50	\$855.00
Family	\$903.00	\$562.00	\$1,465.00

Vendor Contact Information

Healthcare	Prescriptions
Blue Cross of California P.O. Box 60007 Los Angeles, CA 90060-0007 800-227-3613 – Medical	Wellpoint Pharmacy 800-700-2541 - Prescriptions www.bluecrossca.com

Summary of Benefits and Copayments for 2007

This Summary of Benefits is a brief review of benefits. Once enrolled, members will receive the Combined Evidence of Coverage and Disclosure Form, which explains the exclusions and limitations, as well as the full range of covered services of the plan, in detail.

Annual copay maximum: Individual \$500; Two-Party \$1,000; Family \$1,500

The following do not apply to the annual copay maximum: inpatient hospital services, infertility services and inpatient detoxification services

Covered Services	Per Member Copay
Inpatient Medical Services	
Semi-private room or private room if medically necessary; meals and special diets; services and supplies	\$250 per stay *
Special care units	No copay
Operating room and special treatment rooms	No copay
Nursing care	No copay
Drugs, medications & oxygen administered in the hospital	No copay
Blood & blood products	No copay
Outpatient Medical Services	
(Hospital care other than emergency room services)	No copay

Covered Services	Per Member Copay
Ambulatory Services Outpatient surgery & supplies	No copay
Skilled Nursing Facility (Medical conditions & severe mental disorders limited to 100 days/calendar year) All necessary services & supplies (excluding take-home drugs)	No copay
Hospice Care (Inpatient or outpatient services for members with up to one year life expectancy; family bereavement services)	No copay
Home Health Care Home visits when ordered by primary care physician (Limited to 100 visits/calendar year; one visit by a home health aide equals four hours or less)	\$15/visit

Covered Services	Per Member Copay
Physician Medical Services Office & home visits Hospital visits Skilled nursing facility visits Specialists & consultants	\$15/visit No copay No copay \$15/visit
Short-Term Physical, Occupational, or Speech Therapy, or Chiropractic Care when Ordered by the Primary Care Physician (Limited to a 60-day period of care after an illness or injury; additional visits available when approved by the medical group)	\$15/visit
Acupuncture	\$15/visit
Surgical Services Surgeon & surgical assistant Anesthesiologist or anesthetist	No copay No copay

Covered Services	Per Member Copay
<p>General Medical Services</p> <p>Diagnostic X-ray & laboratory procedures (including mammograms, pap smears, & prostate cancer screening)</p> <p>Radiation therapy, chemotherapy & hemodialysis treatment</p> <p>Prosthetic devices</p> <p>Durable medical equipment including hearing aids (limited to \$5,000/calendar year)</p>	<p>No copay</p> <p>No copay</p> <p>No copay</p> <p>No copay</p>
<p>Preventive Care</p> <p>Complete physical exams & periodic routine checkups when ordered by the primary care physician</p> <p>Well-baby & well-child care</p> <p>Well-woman exams</p> <p>Hearing exams</p>	<p>\$15/exam</p> <p>\$15/exam</p> <p>\$15/exam</p> <p>\$15/exam</p>
<p>Vision Exams</p> <p>Vision screening from primary care physician (vision screening covers evaluation only; diagnostic & treatment programs, including refractions, from an optometrist or ophthalmologist must be authorized by the primary care physician)</p>	<p>\$15/exam</p>
Covered Services	Per Member Copay
<p>Health Education and Wellness Programs</p> <p>Specified immunizations</p> <p>Allergy testing & treatment (including serums)</p> <p>Instruction in health maintenance & wellness</p> <p>Health education programs</p>	<p>No copay</p> <p>\$15/visit</p> <p>No copay</p> <p>Possible charge</p>
<p>Emergency Care In Area (within 20 miles of medical group) and Out of Area</p> <p>Physician & medical services</p> <p>Outpatient hospital emergency room services</p> <p>Inpatient hospital services</p>	<p>No copay</p> <p>\$100/visit (waived if admitted)</p> <p>\$250 per stay *</p>

Covered Services	Per Member Copay
Ambulance Services Ground or air ambulance transportation when medically necessary, including medical services & supplies	No copay
Pregnancy and Maternity Care Office Visits Prenatal & postnatal care Complications of pregnancy or therapeutic abortions Normal Delivery or Cesarean Section, including: Inpatient hospital & ancillary services Routine nursery care Physician services (inpatient only) Complication of Pregnancy or Therapeutic Abortion, including: Inpatient hospital & ancillary services Outpatient hospital services Physician services (inpatient only)	 \$15/visit \$15/visit \$250 per stay * No copay No copay \$250 per stay * No copay No copay
Elective Abortions (including prescription drug for abortion [mifepristone])	\$150
Genetic Testing of Fetus	No copay

Covered Services	Per Member Copay
Family Planning Services Infertility studies & tests Tubal ligation Vasectomy Counseling & consultation	50% of covered expense* \$150 \$100 \$15/visit
Organ and Tissue Transplant Inpatient Care Physician office visits (including primary care, specialty care & consultants)	\$250 per stay * \$15/visit
Mental or Nervous Disorders Inpatient Care Facility-based care (preauthorization required) Physician hospital visits Outpatient Care Outpatient mental health consultation (Limited to one visit/day & 20 visits/12-month period)	Not covered** Not covered** \$35/visit**
Acute Alcoholism or Drug Abuse Inpatient Care (acute phase only) Inpatient detoxification for alcohol or drug dependence	\$250 per stay *

*Not applicable to the annual copay maximum.

**These limitations, copays and benefit maximums do not apply to severe mental disorders, including schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia, bulimia, and serious emotional disturbances of children as defined in California state law (other than primary substance abuse or developmental disorder). Severe mental disorders are subject to the same copays and benefit maximums applicable to other medical conditions for covered services. In order to receive coverage, services must be rendered by a Blue Cross behavioral health provider. Please see the EOC for complete information.

Outpatient Prescriptions	Per Member Copay for Each Prescription or Refill
Retail Pharmacy <ul style="list-style-type: none"> • Generic drugs • Brand name formulary drugs • Brand name non-formulary drugs ¹ • Self-administered injectable drugs, except insulin 	\$10 \$20 \$40 20% of prescription drug covered expenses <i>(Maximum \$100 copay)</i>
Mail Service <ul style="list-style-type: none"> • Generic drugs • Brand name formulary drugs • Brand name non-formulary drugs ¹ • Self-administered injectable drugs, except insulin 	\$20 \$40 \$80 20% of prescription drug covered expenses <i>(Maximum \$100 copay)</i>
Non-participating Pharmacies	<i>Member pays the above copay plus:</i> 50% of the remaining prescription drug covered expense & costs in excess of the maximum amount allowed
Supply Limits ² <ul style="list-style-type: none"> • Retail Pharmacy <i>(participating and non-participating)</i> • Mail Service 	30-day supply; 60-day supply for federally classified Schedule II attention deficit disorder drugs that require a triplicate prescription form, but require a double copay; 6 tablets or units/30-day period for impotence and/or sexual dysfunction drugs (available only at retail pharmacies) 90-day supply

¹ When the member's physician has specified "dispense as written" (DAW) for non-formulary drugs, the copay for brand name formulary drugs will apply. When the member's physician has not specified DAW for non-formulary drugs, the higher copay will apply.

² Supply limits for certain drugs may be different. Please refer to the Evidence of Coverage and Disclosure form (EOC) for complete information.

[This information is deemed to be accurate. In the event that this information is in conflict with the vendor contract or the policy, the contract or policy language will prevail. The employers intend to provide these programs on an ongoing basis; however, they reserve the right to amend or terminate any program at any time.]