PPO
Benefit Summaries

Medical Benefits	CalChoice® PPO 750*		CalChoice® PPO 1000		CalChoice® PPO 2400	
	IN-NETWORK	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
Deductible[1] / Family Maximum	$750 - 3 Aggregate	$750 - 3 Aggregate	$1,000 - 3 Aggregate	$1,000 - 3 Aggregate	$2,400 - 3 Aggregate	$2,400 - 3 Aggregate
DR. OFFICE VISITS	**$35 Copay[2]**	**50%[1]**	**$35 Copay[2]**	**50%[1]**	**$40 copay[2]**	**50%[1]**
Annual Physical Exam	$35 Copay[2]	Not Covered	$35 Copay[2]	Not Covered	$40 Copay[2]	Not Covered
Lab And X-Ray	$35 Copay[2]	50%[3]	$35 Copay[2]	50%[3]	70%[2]	50%[3]
HOSPITAL SERVICES	**$500 Copay - 80%**	**50%[3]**	**$1,000 Ded. - 70%**	**50%[3]**	**$500 Copay[1] - 70%**	**50%[3]**
Inpatient Physician Fees	80%	50%[3]	70%	50%[3]	70%	50%[3]
Emergency Room	$150 Copay[1] - 80%	$150 Copay[1] - 80%	$150 Copay[1] - 70%	$150 Copay[1] - 70%	$150 Copay[1] - 70%	$150 Copay[1] - 70%
Rx BENEFITS[1]						
Generic Formulary	**$15 Copay**	**$15 Copay**	**$15 Copay**	**$15 copay**	**$15 copay**	**$15 Copay**
Formulary Brand	**$150 Ded. - $30 Copay**	**$150 Ded. - $30 Copay**	**$200 Ded. - $30 Copay**	**$200 Ded. - $30 Copay**	**$250 Ded. - $30 Copay**	**$250 Ded. - $30 Copay**
Non-Formulary Brand	**$150 Ded. - $50 Copay**	**$150 Ded. - $50 Copay**	**$200 Ded. - $50 Copay**	**$200 Ded. - $50 Copay**	**$250 Ded. - $50 Copay**	**$250 Ded. - $50 Copay**
Oral Contraceptives	Covered	Covered	Covered	Covered	Covered	Covered
Maternity	See Hospital Services		See Hospital Services		See Hospital Services	
Chiropractic	80% - Max. 12 Visits per year	50% - Max. 12 Visits per year	70% - Max. 12 Visits per year	50% - Max. 12 Visits per year	70%[4] - Max. 12 Visits per year	50%[4] - Max. 12 Visits per year
Out-of-Pocket Max. – Ind./Fam.	$3,750 / $7,500	$10,000 / $20,000	$4,000 / $8,000	$10,000 / $20,000	$5,000 / $10,000	$10,000 / $20,000
Lifetime Maximum	$6,000,000	$6,000,000	$6,000,000	$6,000,000	$6,000,000	$6,000,000
Outpatient Surgery	$500 Copay[1] - 80%	50%[3]	$500 Copay[1] - 70%	50%[3]	$500 Copay[1] - 70%	50%[3]
Hospital Pre-Authorization	Required or Additional $250 Hospital Admission		Required or Additional $250 Hospital Admission		Required or Additional $250 Hospital Admission	
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 HR 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
Skilled Nursing Facility	80% - Max. 100 days per year	50%[3] - Max. 100 days per year	70% - Max. 100 days per year	50%[3] - Max. 100 days per year	70% - Max. 100 days per year	50%[3] - Max. 100 days per year
Ambulance	50%	50%	70%	70%	70%	70%
Mental & Nervous Benefits:						
Outpatient - Severe condition	$35 Copay[2]	50%[1]	$35 Copay[2]	50%[1]	$40 copay[2]	50%[1]
Inpatient - Severe condition	$500 Copay - 80%	50%[3]	$1,000 Ded. - 70%	50%[3]	$500 Copay - 70%	50%[3]
Outpatient - Non-Severe	50% - Max. 20 Visits per year	Not Covered	50% - Max. 20 Visits per year	Not Covered	50% - Max. 20 Visits per year	Not covered
Inpatient - Non-Severe	$500 Copay - 80%	50%[3]	$1,000 Ded. - 70%	50%[3]	$500 Copay - 70%	50%[3]
Drug & Alcohol Benefits:						
Inpatient	$500 Copay - 80% Detox Only	50% Detox Only[3]	$1,000 Ded. - 70% Detox Only	50% Detox Only[3]	$500 Copay - 70% Detox Only	50% Detox Only[3]

* Available to groups with 10 or more employees.

Note: Out-of-Network benefits are covered at a Negotiated Fee. Plans exclude coverage for pre-existing conditions (except for pregnancy) for the first six months of coverage unless replacing prior creditable coverage.

Some services rendered by Blue Shield Affiliated providers will have higher copays. Please refer to the California*Choice*® Program brochure for more detailed plan benefit information.

1 Copay for services do not count toward the Copay Maximum, and continue to be charged once the Copay Maximum is reached.
2 The office visit copay is not subject to the Plan deductible. Other covered services received during or in connection with the office visit, such as lab tests and x-rays, are subject to the Plan deductible and the applicable copay.
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 service and Respiratory visits.

800.542.4218
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