healthcare for the way we live®

Enrollment Guide for Employees

Blue Shield of California | Health Net | Kaiser Permanente
Sharp Health Plan | Western Health Advantage

CaliforniaChoice®
Your Health. Your Choice.®

Healthcare for the way We Live®

Congratulations! Your employer has decided to offer health insurance coverage through California*Choice*, giving you more options than any other program available in California. Now you can select the health plan of your choice and the benefits that are right for you and your family.

What is California*Choice*?

California*Choice* is a health insurance program that allows you to choose from multiple health plans and benefit options.

How California*Choice* works for you:

- Allows you to customize a healthcare plan that meets your individual needs
- Offers you more choices, greater flexibility and increased convenience
- Provides you with more affordability, greater access, choice and satisfaction

What do you get?

- Medical HMO, PPO and HSA compatible plans
- Dental Prepaid, PPO and EPO plans
- Prescription benefit options
- Discount vision, dental and chiropractic services

Your Health Plan Choices:

blue of california

Health Net® A Better Decision

KAISER PERMANENTE®

SHARP HEALTH PLAN

Western Health Advantage

Your Benefit Choices

HMO

An HMO provides medical services through contracted physicians and hospitals. All healthcare services are managed in-network through your Primary Care Physician (PCP).

- You first select a PCP (your doctor)
- Referrals to hospitals and specialists are managed by your PCP
- You pay a low copay for each office visit

Health Net Elect Open Access

An HMO benefit that has a self-referral feature to PPO doctors. Members pay $25 to see their HMO PCP, or for a $40 copay, can self-refer to a Health Net PPO doctor or specialist.

- Elect Open Access is priced like an HMO but gives you access to PPO doctors through its network of more than 44,000 physicians
- You first select a Primary Care Physician
- Your PCP coordinates all your care including all major services such as hospitalization and surgery
- You have unlimited access to any physician or specialist in the Health Net PPO network without a referral

PPO*

A PPO provides benefits within the health plan's network of doctors with the option of going "out-of-network" for slightly higher costs.

- PPOs do not require you to select a PCP
- You can see any doctor but your benefits are not as rich when you see "out-of-network" doctors
- You will pay less for seeing an "in-network" doctor
- Pre-existing conditions may apply if you do not have prior medical coverage

Health Savings Account (HSA)

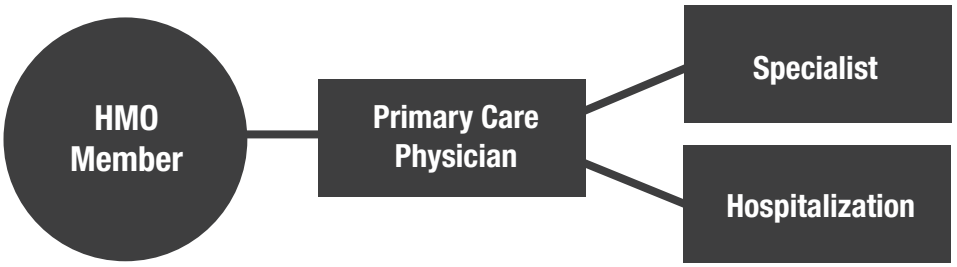
HSAs offer great benefits with lower monthly premiums and the ability to save for future medical expenses - tax-free.

- Contributions to your HSA are tax-deductible
- Withdrawals from your HSA are tax-free when used for qualified medical expenses like doctor visits and prescriptions
- Funds in your HSA keep earning tax-deferred interest year-after-year

* PPO benefits are based on group size. Please see the top of page 12 for details.

HMO Benefits

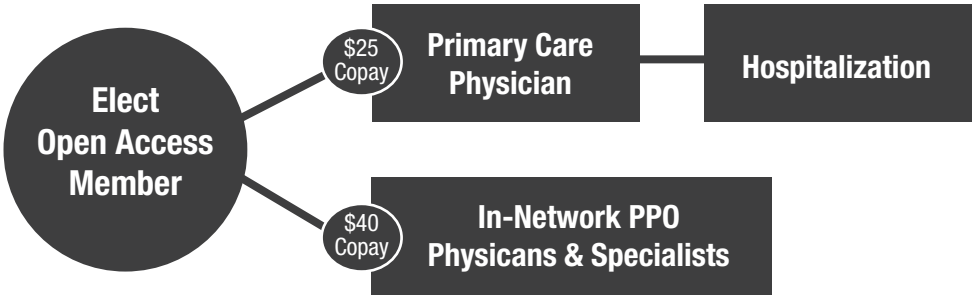
Under an HMO plan, all access to specialists and hospitalization must be determined through the member's Primary Care Physician (PCP).



Elect Open Access

(Health Net only)

Under the Elect Open Access plan, members must choose a Primary Care Physician (PCP). However, for a $40 copay, members may self-refer to any doctor in the Elect Open Access listing in the California*Choice*® Provider Directory. In-hospital benefits must be determined by a member's PCP.



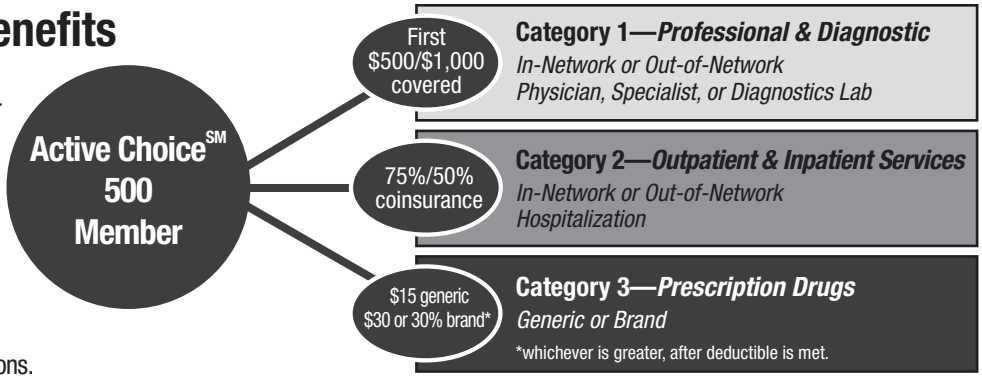
PPO Benefits

(Blue Shield only)

Under a PPO plan, members do not choose a Primary Care Physician (PCP). PPO members may self-refer to specialists. Members can receive care from 2 levels of in-network doctors or go out-of-network for lower benefits.

Active Choice℠ 500 Benefits

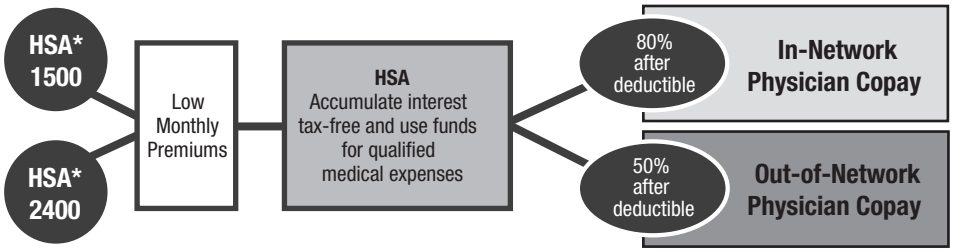
Active Choice℠ 500 offers services in three categories. Category One covers first dollar amounts up to $500 for an individual or $1000 for family. Once the first dollar limit has been met, the member is responsible for charges up to the calendar year copay maximum. Category Two covers outpatient surgeries, emergency room and inpatient services at the plan copay and coinsurance amounts. Category Three covers prescriptions.



Health Savings Account (HSA) Benefits

Members receive comprehensive medical coverage and have the option to contribute tax-deductible funds into a Health Savings Account (HSA) and accumulate tax-deferred interest. HSA members do not pay taxes on withdrawals when paying for qualified medical expenses.

*HSA - Qualified High Deductible Health Plan



HMO SUMMARY OF BENEFITS

Services	CalChoice® HMO 15	CalChoice HMO 25	CalChoice HMO 25	CalChoice HMO 25
Available Through:	Blue Shield, Health Net, Kaiser Permanente, Sharp, Western Health Advantage	Blue Shield, Sharp, Western Health Advantage	Health Net	Kaiser Permanente
Calendar Year Deductible	None	None	None	None
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Professional Services (Office Visits) Physician services (office, specialists - other than surgery or therapy); allergy testing, treatment and serum; diagnostic x-ray and lab	$ 15	$ 25	$ 25	$ 25
Professional Services (Diagnostic) Laboratory services; diagnostic and therapeutic radiological services and other diagnostic services, including electrocardiography (EKG) and electroencephalography (EEG)	$ 15	$ 25	$ 25	$ 5
Professional Services (Preventive) Routine physical exams on a periodic age-appropriate basis; prenatal services; breast and pelvic exams; pap smears; cervical cancer screening; mammography for screening or diagnostic purposes; immunizations for children and adults; preventive care for children; well-baby care	$ 15	$ 25	$ 25	$ 25
Out-Patient Surgery Services Surgical Facility	$ 200	$ 300	$ 400	$ 300
Hospitalization Services (In-patient) General hospital services, including semi-private room; intensive care unit and services; drugs; medications; anesthesia and oxygen services; diagnostic x-ray and lab Hospital Pregnancy & Maternity Care	$ 400 Copay - 100%	$ 400 Copay per day Max. $ 1,200	$ 450 Copay per day Max. $ 1,800	$ 400 Copay - 100%
Emergency Room/Health Coverage Copay waived if admitted to hospital	$ 100	$ 150	$ 150	$ 150
Ambulance Services (per trip)	$ 50	$ 100	$ 200	$ 100
Physical, Occupational, Speech Therapy	$ 15[1]	$ 25[1]	$ 25	$ 25
Prescriptions Per 30 day supply or 100 unit doses, HCSP is allowed to use a generic or formulary brand	$ 10 Generic $ 20 Brand	$ 15 Generic $ 100 Ded. - $ 30 Brand	$ 15 Generic $ 100 Ded. - $ 30 Brand	$ 10 Generic $ 25 Brand
	Non-formulary Rx coverage varies by health plan. See the Health Plan & Formulary Comparison Guide.			
Durable Medical Equipment (Covered when medically necessary as determined by HCSP)	Covered at 90% of allowed charges Max. $ 2,500 per year	Covered at 70% of allowed charges Max. $ 2,500 per year	Covered at 50% of allowed charges Max. $ 2,500 per year	Covered at 70% of allowed charges Max. $ 2,500 per year
Mental Health/Substance Abuse Services Out-patient - 20 visits per year (Provisions of AB 88 apply - see page 21)	$ 30	$ 40	$ 40	$ 25
Infertility Evaluation and Treatment	50% of allowed charges	50% of allowed charges	50% of allowed charges	50% of allowed charges
Copay Maximum (per calendar year)	$ 2,000 Sgl. $ 4,000 Fam.	$ 2,500 Sgl. $ 5,000 Fam.	$ 3,000 Sgl. $ 6,000 Fam.	$ 2,500 Sgl. $ 5,000 Fam.

1 For Sharp HMO, 30 visits combined per calendar year applies.

Note: These services are covered benefits only when and to the extent that they are provided, prescribed, or directed by the Healthcare Service Plan (HCSP) you have selected, except in emergencies. Each HCSP is responsible for administering these benefits pursuant to its administrative procedures, medical protocols and medical review criteria and procedures. The benefits are subject to various limitations, exclusions and conditions, as noted on page 21 and fully described in each HCSP's *Evidence of Coverage* document and the program regulations. If you would like more information prior to enrollment, or wish to request an *Evidence of Coverage* document, please contact the HCSP(s) you are interested in, using the telephone number listed on the back page of this brochure. All services covered by your selected HCSP are fully described in the EOC document that will be mailed to you once you have enrolled and are accepted for coverage through the California*Choice*® Program.

Services	CalChoice® HMO 25 Value	CalChoice HMO 25 Value	Elect Open Access	Salud HMO y mas[1]
Available Through:	Health Net	Blue Shield	Health Net	Health Net
Calendar Year Deductible	None	$ 1,000 Sgl./ $ 2,000 Fam. (Applies to Copay Max)	None	None
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Professional Services (Office Visits) Physician services (office, specialists - other than surgery or therapy); allergy testing, treatment and serum; diagnostic x-ray and lab	$ 25	$ 25	$ 25 Copay HMO $ 40 Copay PPO	$ 25
Professional Services (Diagnostic) Laboratory services; diagnostic and therapeutic radiological services and other diagnostic services, including electrocardiography (EKG) and electroencephalography (EEG)	$ 25	$ 25	75%	100%
Professional Services (Preventive) Routine physical exams on a periodic age-appropriate basis; prenatal services; breast and pelvic exams; pap smears; cervical cancer screening; mammography for screening or diagnostic purposes; immunizations for children and adults; preventive care for children; well-baby care	$ 25	$ 25	$ 25	$ 25
Out-Patient Surgery Services Surgical Facility	75%	$ 400 Copay after deductible	75%	$ 300
Hospitalization Services (In-patient) General hospital services, including semi-private room; intensive care unit and services; drugs; medications; anesthesia and oxygen services; diagnostic x-ray and lab Hospital Pregnancy & Maternity Care	75%	$ 400 Copay per day after deductible, Max. $ 1,600	75%	$ 500 Copay per day Max. $ 1,000
Emergency Room/Health Coverage Copay waived if admitted to hospital	$ 150	$ 150	75%	$ 100
Ambulance Services (per trip)	$ 200	$ 100	100%	$ 50
Physical, Occupational, Speech Therapy	$ 25	$ 25	$ 25	$ 25
Prescriptions Per 30 day supply or 100 unit doses, HCSP is allowed to use a generic or formulary brand	$ 15 Generic $ 100 Ded. - $ 30 Brand	$ 15 Generic $ 200 Ded. - $ 30 Brand	$ 15 Generic $ 150 Ded. - $ 30 Brand	$ 15 Generic $ 25 Brand
	Non-formulary Rx coverage varies by health plan. See the Health Plan & Formulary Comparison Guide.			
Durable Medical Equipment (Covered when medically necessary as determined by HCSP)	Covered at 50% of allowed charges, Max. $ 2,500 per year	Covered at 50% of allowed charges, Max. $ 2,500 per year	Covered at 50% of allowed charges, Max. $ 2,500 per year	Covered at 70% of allowed charges, Max. $ 2,500 per year
Mental Health/Substance Abuse Services Out-patient - 20 visits per year (Provisions of AB 88 apply - see page 21)	$ 40	$ 40	$ 30	$ 40
Infertility Evaluation and Treatment	50% of allowed charges	50% of allowed charges	50% of allowed charges	50% of allowed charges
Copay Maximum (per calendar year)	$ 3,000 Sgl. $ 6,000 Fam.	$ 3,000 Sgl. $ 6,000 Fam.	$ 2,500 Sgl. $ 6,000 Fam.	$ 2,500 Sgl. $ 5,000 Fam.

1 Salud HMO y Mas benefits shown are for the Salud Network. Please see Salud Application/Brochure for SIMNSA Network benefits.

Note: These services are covered benefits only when and to the extent that they are provided, prescribed, or directed by the Healthcare Service Plan (HCSP) you have selected, except in emergencies. Each HCSP is responsible for administering these benefits pursuant to its administrative procedures, medical protocols and medical review criteria and procedures. The benefits are subject to various limitations, exclusions and conditions, as noted on page 21 and fully described in each HCSP's *Evidence of Coverage* document and the program regulations. If you would like more information prior to enrollment, or wish to request an *Evidence of Coverage* document, please contact the HCSP(s) you are interested in, using the telephone number listed on the back page of this brochure. All services covered by your selected HCSP are fully described in the EOC document that will be mailed to you once you have enrolled and are accepted for coverage through the California*Choice*® Program.

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.

HMO SUMMARY OF BENEFITS

Services	CalChoice® HMO 30	CalChoice HMO 30	CalChoice HMO 30 Value	CalChoice HMO 40
Available Through:	Blue Shield, Health Net, Sharp, Western Health Advantage	Kaiser Permanente	Health Net	Blue Shield, Health Net, Sharp, Western Health Advantage
Calendar Year Deductible	None	None	None	None
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Professional Services (Office Visits) Physician services (office, specialists - other than surgery or therapy); allergy testing, treatment and serum; diagnostic x-ray and lab	$ 30[1]	$ 30[1]	$ 30[1]	$ 40[1]
Professional Services (Diagnostic) Laboratory services; diagnostic and therapeutic radiological services and other diagnostic services, including electrocardiography (EKG) and electroencephalography (EEG)	$ 30[1]	$ 10[1]	$ 30[1]	$ 40[1]
Professional Services (Preventive) Routine physical exams on a periodic age-appropriate basis; prenatal services; breast and pelvic exams; pap smears; cervical cancer screening; mammography for screening or diagnostic purposes; immunizations for children and adults; preventive care for children; well-baby care	$ 30[1]	$ 30[1]	$ 30[1]	$ 40[1]
Out-Patient Surgery Services Surgical Facility	$ 400[1]	$ 400[1]	70%[1]	$ 500[1]
Hospitalization Services (In-patient) General hospital services, including semi-private room; intensive care unit and services; drugs; medications; anesthesia and oxygen services; diagnostic x-ray and lab Hospital Pregnancy & Maternity Care	$ 450 Copay per day[1] Max. $1,800	$ 450 Copay – 100%[1]	70%[1]	$ 500 Copay per day[1]
Emergency Room/Health Coverage Copay waived if admitted to hospital	$ 200[1]	$ 200[1]	$ 200[1]	$ 250[1]
Ambulance Services (per trip)	$ 200[1]	$ 200[1]	$ 200[1]	$ 200[1]
Physical, Occupational, Speech Therapy	$ 30[1,2]	$ 30[1]	$ 30[1]	$ 40[1,2]
Prescriptions Per 30 day supply or 100 unit doses, HCSP is allowed to use a generic or formulary brand	$ 15 Generic[1] $ 150 Ded. - $ 30 Brand[1]	$ 15 Generic[1] $ 30 Brand[1]	$ 20 Generic[1] $ 200 Ded. - $ 30 Brand[1]	$ 20 Generic $ 200 Ded. - $30 Brand[1]
	Non-formulary Rx coverage varies by health plan. See the Health Plan & Formulary Comparison Guide.			
Durable Medical Equipment (Covered when medically necessary as determined by HCSP)	Covered at 50% of allowed charges Max. $ 2,500 per year	Covered at 50% of allowed charges Max. $ 2,500 per year	Covered at 50% of allowed charges Max. $ 2,500 per year	Covered at 50% of allowed charges Max. $ 2,500 per year
Mental Health/Substance Abuse Services Out-patient - 20 visits per year (Provisions of AB 88 apply - see page 21)	$ 40[1]	$ 30[1]	$ 40[1]	$ 50[1]
Infertility Evaluation and Treatment	50% of allowed charges	50% of allowed charges	50% of allowed charges	50% of allowed charges
Copay Maximum (per calendar year)	$ 3,000 Sgl. $ 6,000 Fam.	$ 3,000 Sgl. $ 6,000 Fam.	$ 3,500 Sgl. $ 7,000 Fam.	$ 3,500 Sgl. $ 7,000 Fam.

1 Copay shall be up to the designated amount, or 50% of the provider's contracted rate, whichever is less.

2 For Sharp HMO, 30 visits combined per calendar year applies.

Note: These services are covered benefits only when and to the extent that they are provided, prescribed, or directed by the Healthcare Service Plan (HCSP) you have selected, except in emergencies. Each HCSP is responsible for administering these benefits pursuant to its administrative procedures, medical protocols and medical review criteria and procedures. The benefits are subject to various limitations, exclusions and conditions, as noted on page 21 and fully described in each HCSP's *Evidence of Coverage* document and the program regulations. If you would like more information prior to enrollment, or wish to request an *Evidence of Coverage* document, please contact the HCSP(s) you are interested in, using the telephone number listed on the back page of this brochure. All services covered by your selected HCSP are fully described in the EOC document that will be mailed to you once you have enrolled and are accepted for coverage through the California*Choice*® Program.

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.

Services	Cal*Choice*® HMO 40	Cal*Choice* HMO 40 Value	Cal*Choice* HMO 40 Value	Cal*Choice* HMO 40 Value
Available Through:	Kaiser Permanente	Health Net	Blue Shield	Western Health Advantage
Calendar Year Deductible	None	None	$ 1,500 Sgl./ $ 3,000 Fam. (Applies to Copay Max)	$ 2,500 Sgl./ $ 5,000 Fam. (Applies to Copay Max)
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Professional Services (Office Visits) Physician services (office, specialists - other than surgery or therapy); allergy testing, treatment and serum; diagnostic x-ray and lab	$ 40[1]	$ 40[1]	$ 40[1]	$ 40[1]
Professional Services (Diagnostic) Laboratory services; diagnostic and therapeutic radiological services and other diagnostic services, including electrocardiography (EKG) and electroencephalography (EEG)	$ 10[1]	$ 40[1]	$ 40[1]	No Charge
Professional Services (Preventive) Routine physical exams on a periodic age-appropriate basis; prenatal services; breast and pelvic exams; pap smears; cervical cancer screening; mammography for screening or diagnostic purposes; immunizations for children and adults; preventive care for children; well-baby care	$ 40[1]	$ 40[1]	$ 40[1]	$ 40[1]
Out-Patient Surgery Services Surgical Facility	$ 500[1]	60%[1]	$ 750 Copay after[1] deductible	$ 250[1]
Hospitalization Services (In-patient) General hospital services, including semi-private room; intensive care unit and services; drugs; medications; anesthesia and oxygen services; diagnostic x-ray and lab Hospital Pregnancy & Maternity Care	$ 500 Copay per day[1]	60%[1]	$ 750 Copay per day after deductible[1]	$ 500 Copay per day after deductible[1]
Emergency Room/Health Coverage Copay waived if admitted to hospital	$ 250[1]	$ 250[1]	$ 250[1]	$ 250 after deductible[1]
Ambulance Services (per trip)	$ 200[1]	$ 200[1]	$ 200[1]	$ 50[1]
Physical, Occupational, Speech Therapy	$ 40[1]	$ 40[1]	$ 40[1] after deductible	$ 40[1]
Prescriptions Per 30 day supply or 100 unit doses, HCSP is allowed to use a generic or formulary brand	$ 15 Generic[1] $ 30 Brand[1]	$ 20 Generic[1] $ 200 Ded. - $ 30 Brand[1]	$ 15 Generic[1] $ 250 Ded. - $ 30 Brand[1]	$ 20 Generic[1] $ 250 Ded. - $ 30 Brand[1]
	Non-formulary Rx coverage varies by health plan. See the Health Plan & Formulary Comparison Guide.			
Durable Medical Equipment (Covered when medically necessary as determined by HCSP)	Covered at 50% of allowed charges Max. $ 2,500 per year	Covered at 50% of allowed charges Max. $ 2,500 per year	Covered at 50% of allowed charges Max. $ 2,500 per year	Covered at 80% of allowed charges Max. $ 2,500 per year
Mental Health/Substance Abuse Services Out-patient - 20 visits per year (Provisions of AB 88 apply - see page 21)	$ 40[1]	$ 50[1]	$ 50[1]	$ 40[1]
Infertility Evaluation and Treatment	50% of allowed charges	50% of allowed charges	50% of allowed charges	50% of allowed charges
Copay Maximum (per calendar year)	$ 3,500 Sgl. $ 7,000 Fam.	$ 3,500 Sgl. $ 7,000 Fam.	$ 4,000 Sgl. $ 8,000 Fam.	$ 5,000 Sgl. $ 10,000 Fam.

1 Copay shall be up to the designated amount, or 50% of the provider's contracted rate, whichever is less.

Note: These services are covered benefits only when and to the extent that they are provided, prescribed, or directed by the Healthcare Service Plan (HCSP) you have selected, except in emergencies. Each HCSP is responsible for administering these benefits pursuant to its administrative procedures, medical protocols and medical review criteria and procedures. The benefits are subject to various limitations, exclusions and conditions, as noted on page 21 and fully described in each HCSP's *Evidence of Coverage* document and the program regulations. If you would like more information prior to enrollment, or wish to request an *Evidence of Coverage* document, please contact the HCSP(s) you are interested in, using the telephone number listed on the back page of this brochure. All services covered by your selected HCSP are fully described in the EOC document that will be mailed to you once you have enrolled and are accepted for coverage through the California*Choice*® Program.

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 SUMMARY OF BENEFITS

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
Calendar Year Deductibles[1] *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	Out of Network	In Network	Out of Network	In Network	Out of Network
Physician Services — Out-patient						
PCP or OB Office Visit	$ 35 Copay[2]	50%[1]	$ 35 Copay[2]	50%[1]	$ 40 Copay[2]	50%[1]
Specialist Office Visit	$ 35 Copay[2]	50%[1]	$ 35 Copay[2]	50%[1]	$ 40 Copay[2]	50%[1]
Mammogram and PAP Test	$ 35 Copay[2]	50%	$ 35 Copay[2]	50%	$ 40 Copay[2]	50%[1]
Laboratory, X-Ray & Diagnostic *Deductible Applies*	$ 35 Copay[2]	50%[3]	$ 35 Copay[2]	50%[3]	70%[2]	50%[3] (max. $ 600/visit)
Physician Services — In-patient						
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 *Not subject to cal. yr. deductible*						
Annual Physical Exam *Including eye/ear screening, immunizations up to age 17*	$ 35 Copay[2]	Not Covered	$ 35 Copay[2]	Not Covered	$ 40 Copay[2]	Not Covered
Mammogram and Pap Test	$ 35 Copay[2]	Not Covered	$ 35 Copay[2]	Not Covered	$ 40 Copay[2]	Not Covered
Laboratory	$ 35 Copay[2]	Not Covered	$ 35 Copay[2]	Not Covered	$ 40 Copay[2]	Not Covered
Hospital Services — Out-patient						
Out-patient 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[1] then: 70%	50%[3] (to $ 600 a day)
Hospital Services — In-patient						
Room, Board, Service and Supplies *Skilled Nursing Facility* *Max. 100 Days PPO 750 & 1000* *In Hospital* *Max. 60 Days PPO 2400*	$ 500 copay then: 80%	50%[3] (to $ 600 a day)	$ 1,000 Ded. then: 70%	50%[3] (to $ 600 a day)	$ 500 copay[1] then: 70%	50%[3] (to $ 600 a day)

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.

Benefits, con't	CalChoice® PPO 750		CalChoice PPO 1000		CalChoice PPO 2400	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Pregnancy & Maternity Care Prenatal and postnatal care All necessary in-patient hospital services	80%	50%	70%	50%	70%	50%
Emergency Services ER Facility Resulting In Immediate Admission	Covered Under In-patient Hospital					
ER Facility Not Resulting In Admission ER Physician Services (Not Resulting In Admission)	$ 150 Copay[1] then: 80%	$ 150 Copay[1] then: 80%	$ 150 Copay[1] then: 70%	$ 150 Copay[1] then: 70%	$ 150 Copay[1] then: 70%	$ 150 Copay[1] then: 70%
Ambulance	50%	50%	70%	70%	70%	70%
Physical, Occupational, Speech Therapy	80%	50%	70%	50%	70% combined 12 visits per cal yr.	50% combined 12 visits per cal yr.
Home Medical Equipment	50% of allowable amnt. max 2k per yr.	50% of allowable amnt. max 2k per yr.	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 22) Out-patient In-patient	$ 35 Copay[2] $ 500 Copay then: 80%	50%[1] 50%[3] (to $ 600 a day)	$ 35 Copay[2] $ 1,000 Deductible then: 70%	50%[1] 50%[3] (to $ 600 a day)	$ 40 Copay[2] $ 500 Copay then: 70%	50%[1] 50%[3]
Psychiatric - Non Severe Includes Alcohol/Substance Abuse Care Out-patient (Maximum of 20 visits per calendar year)	50%	Not Covered	50%	Not Covered	50%	Not Covered
In-patient (medical acute detoxification only)	Covered Under In-patient 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 PPO 750*/1000**/2400***	Non-Participating Pharmacy PPO 750*/1000**	Non-Participating Pharmacy PPO 2400***	Mail Service Prescriptions PPO 750*/1000**/2400***
Out-patient Prescription Drugs[1] (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 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 Services and Respiratory visits.

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.

HSA COMPATIBLE BENEFITS

Calendar year deductibles for the HSA 1500* Plan are $1,500 for individual and $3,000 for family. Calendar year deductibles for the HSA 2400* Plan are $2,400 for individual and $4,800 for family.	CalChoice® HSA 1500†		CalChoice HSA 2400†	
	Preferred Providers	Non-Preferred Providers	Preferred Providers	Non-Preferred Providers
Calendar Year Deductible (maximum 2 aggregate per family)[2]	See Above	See Above	See Above	See Above
Lifetime Maximum	$ 6 million	$ 6 million	$ 6 million	$ 6 million
Physician Services — Out-patient				
Office visit/consultations (not including routine exams)	80%	50%	80%	50%
Specialist visits and consultations	80%	50%	80%	50%
Laboratory, x-rays, diagnostics	80%	50%[3]	80%	50%[3]
Physician Services — In-patient				
In-patient visits and consultations	80%	50%	80%	50%
Surgeons and assistants, anesthesiologists, pathologists, radiologists	80%	50%	80%	50%
Preventive Benefits (Not subject to the plan's calendar year deductible)				
Annual Routine Physical Exam Office Visit (one per calendar year)	$ 30[1]	Not Covered	$ 35[1]	Not Covered
Annual Pap test, mammography screening	80%	Not Covered	80%	Not Covered
Laboratory, diagnostics, immunizations and vaccinations	80%	Not Covered	80%	Not Covered
Hospital Services — Out-patient				
Out-patient surgery • Renal dialysis	80%	50%[3]	80%	50%[3]
Hospital Services — In-patient				
Semi-private room and board, medically necessary services and supplies, including subacute care	80%	50%[3]	80%	50%[3]
Pregnancy & Maternity Care				
Prenatal and postnatal care	Covered Under	50%[3]	Covered Under	50%[3]
All necessary inpatient hospital services	In-patient Hospital	50%[3]	In-patient Hospital	50%[3]
Emergency Services (Members meet an additional $100 deductible per emergency room visit before benefits apply. This deductible is waived if the member is admitted directly to the hospital)	80%	80%	80%	80%
Ambulance	80%	80%	80%	80%
Physical, Occupational, Speech Therapy	80% (Combined 12 visits per calendar year)	50% (Combined 12 visits per calendar year)	80%	50%
Out-patient Prescription Drugs[4] (Subject to a deductible. Includes oral contraceptives)	$15[4] Generic $30[4] Brand	$15[4] Generic $30[4] Brand	$15[4] Generic $30[4] Brand	$15[4] Generic $30[4] Brand
Home Medical Equipment	50%	50%	50%	50%
Psychiatric				
Out-patient - severe	80%	50%	80%	50%
Out-patient - non-severe (maximum 20 visits — combined with alcohol / substance abuse)	50%	Not Covered	50%	Not Covered
In-patient - severe and non-severe	80%	50%[3]	80%	50%[3]
Alcohol / Substance Abuse				
Out-patient (maximum 20 visits — combined with psychiatric)	Combined benefit with Non-Severe Mental & Nervous	Not Covered	Combined benefit with Non-Severe Mental & Nervous	Not Covered
In-patient (medical acute detox. only)	80%	50%[3]	80%	50%[3]
Hospice - Routine Home Care	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	80% if authorized	80% if authorized or not covered
Chiropractic Services (20 visits per calendar year) Chiropractic manipulative treatment	80%	50%	80%	50%
Out-of-Pocket Maximum (Individual/Family) Includes Plan Deductible	$2,800/$5,600	$2,800/$5,600	$3,200/$5,800	$3,200/$5,800

† All services are subject to calendar year deductible unless otherwise noted. * HSA-Qualified High Deductible Health Plan.

1 The Preventive Care and Well-Baby Care office visit copays do not count toward 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.

2 Employees enrolling for single coverage must satisfy the single deductible; for employees enrolling with dependent coverage, the family deductible must be met before any member receives benefits.

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. These copays do not count toward the calendar year Copay Maximum, and continue to be charged after it is reached. Physician Services are covered separately at 50% of Allowable Amounts.

4 Includes coverage for medically necessary drugs. Members using Out-of-Network pharmacies pay full price and submit prescription drug claims to Blue Shield of California.

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.

Active Choice members can use up to $500 per individual or $1000 per family for preventive care like routine physicals and immunizations, and out-patient professional services like physical therapy and diagnostic testing.

Members pay no out-of-pocket expenses until their first-dollar limit is used and then pay 100% of the charges for covered physician and out-patient services until their calendar year copay maximum is met.

Hospital services Members can begin accessing care without paying deductibles on medical benefits including inpatient and out-patient services such as surgeries and emergency room visits.
Prescription drugs Members receive immediate coverage for generic drugs with just a $15 copay. To receive brand-name drug benefits, a $500 Rx deductible must first be met.
Carry-over credit Any dollars left at the end of the first year can be rolled over to the following calendar year, as long as the member stays on the same plan, with the same employer.

Medical Benefit	Active Choice℠ 500 In Network	Active Choice℠ 500 Out of Network
Deductible (Family maximum)	No Deductible	No Deductible
Lifetime Maximum	$ 6,000,000	$ 6,000,000
Dr. Office Visits Annual Physical Exam Lab and X-Ray	100% up to $ 500/$ 1,000[1,2]	
Hospital Services	$ 500 Copay then 75%	50%[4]
In-Patient Physician Fees	75%	50%
Emergency Room	$ 100 Copay[3] then 75%	$ 100 Copay[3] then 75%
Out-Patient Surgery	$ 400 Copay[3] then 75%	50%[3,4]
Hospital Pre-Authorization	Required or Add'tl $ 250 Hospital Admission	
Maternity	See Hospital Services	See Hospital Services
Ambulance	75%	75%
Physical, Occupational, Speech Therapy	100% up to $ 500/$ 1,000[1,2]	
Mental & Nervous Benefits		
Out-patient - Severe Condition	100% up to $ 500/$ 1,000[1,2]	
In-patient - Severe Condition	$ 500 Copay then 75%	50%[4]
Out-patient - Non-Severe	100% up to $ 500/$ 1,000[1,2]	
In-patient - Non-Severe	$ 500 Copay then 75%	50%[4]
Drug & Alcohol Benefits		
Out-patient	Combined Benefit with Non-Severe Mental & Nervous	
In-patient	$ 500 Copay then 75% detox only	50% detox only[4]
Hospice		
Routine Home Care	100% if authorized	100% if authorized or not covered
24 HR Continuous Care	75% if authorized	75% if authorized or not covered
Skilled Nursing Facility	75%-Max. 100 days/yr.	50%[4]-Max. 100 days/yr.
Chiropractic	100% up to $ 500/$ 1,000[1,2]	

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.

Covered Services	
Out-of-Pocket Maximum (Individual/Family)	$5,000/$10,000
Category One#,†	
Out-patient Professional & Diagnostic • Office visits • Diagnostic testing	First Dollar Services Coverage: $500 Individual/$1,000 Family
Preventive Care • Routine physical exams • Well-baby care • Immunizations	Then the member is responsible for charges up to the calendar-year Copay maximum
Category Two#,†	
Out-patient & In-patient Services • Surgeries • Emergency room visits • Renal dialysis • Chemotherapy	75% / 50% coinsurance (some copays apply)
Category Three††	
Prescription Drugs	
• Generic	$15 Copay
• Brand-name drugs	
– Deductible	$500
– Copay for formulary	$30 or 30% whichever is greater, after deductible is met
– Copay for non-formulary	$50 copay (or 50% of Blue Shield contracted rate) after deductible

\# Out-of-pocket costs above the allowable amount do not apply to the calendar-year copay maximum.

† After copay maximum is met, Blue Shield Life covers benefits at 100 percent of the allowable amount.

†† If the physician or member requests a brand-name drug when a generic drug is available, the member is responsible for the cost difference between the brand and generic drug, in addition to the generic copay.

1 Copays for services do not count toward the Copay Maximum until the first dollar $500 (individual) or $1,000 (family) coverage limit has been reached.

2 The $500 (individual) or $1,000 (family) first dollar covers preventive, outpatient and professional & diagnostic services. After the first $500/$1,000 limit is reached, the member is responsible for all allowed charges until the calendar year maximum is reached; once the calendar year maximum is reached Blue Shield pays 100% of the Allowable Amount. Coverage for non-severe mental & nervous, drug & alcohol and chiropractic benefits are limited to the first dollar amounts for individual and family only.

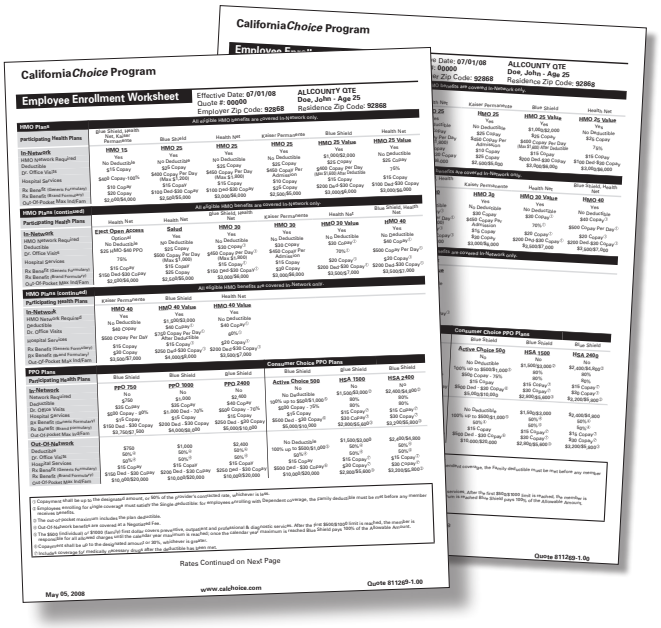
3 Copays for services do not count toward the Copay Maximum, and continue to be charged once the Copay Maximum is reached.

4 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 the Allowable Amount.

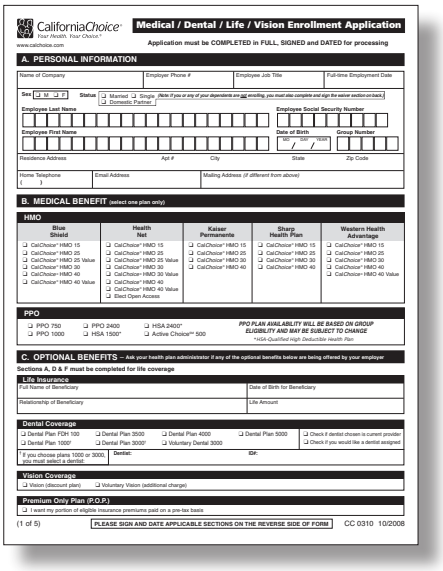
THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE *EVIDENCE OF COVERAGE* AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

It's easy to choose the right benefits with California*Choice*® because we lay it out all for you; from how much your employer is contributing to your benefits, to how much each benefit is for you and/or your dependents to enroll.

Tools You'll Need to Enroll



1. Personalized Worksheet



2. Enrollment Application

Look up your doctor

Before you decide on which plan works best for you, visit our website to see if your doctor is in our network:

- Go to **www.calchoice.com**
- Click on Provider / Rx Search
- Type in the last name of your doctor

If your doctor is not available, we make it easy for you to quickly find a new doctor in your area.

Important Note: Call your doctor prior to enrolling to make sure they still participate in the health plan you have chosen.

Prescription Drugs: If you or a dependent need a specific drug, you can compare health plan coverage using our online Formulary Search at www.calchoice.com

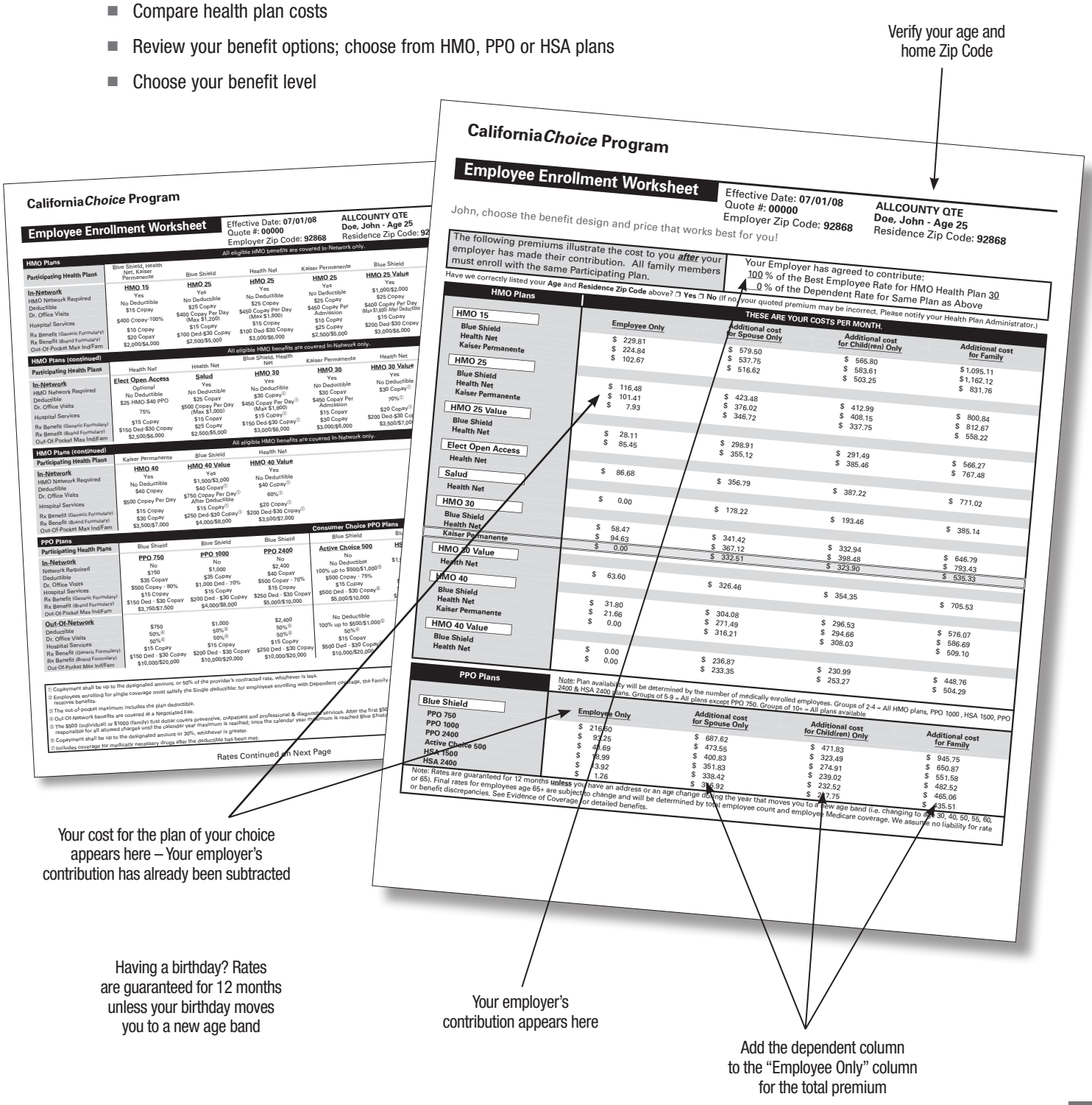
Personalized Worksheet

Your Personalized Worksheet is a great tool because it shows you all of your benefit choices, and the cost associated with each option after your employer's contribution has been removed. This means what you see on your worksheet is exactly what you'll pay each pay period.

You can also see the costs associated with adding a spouse and/or dependents to your coverage.

Use your Personalized Worksheet to:

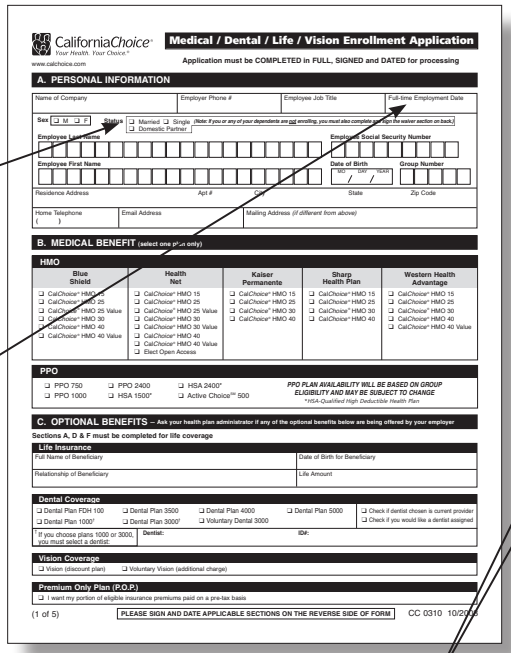
- Compare health plan costs
- Review your benefit options; choose from HMO, PPO or HSA plans
- Choose your benefit level



Enrollment Application

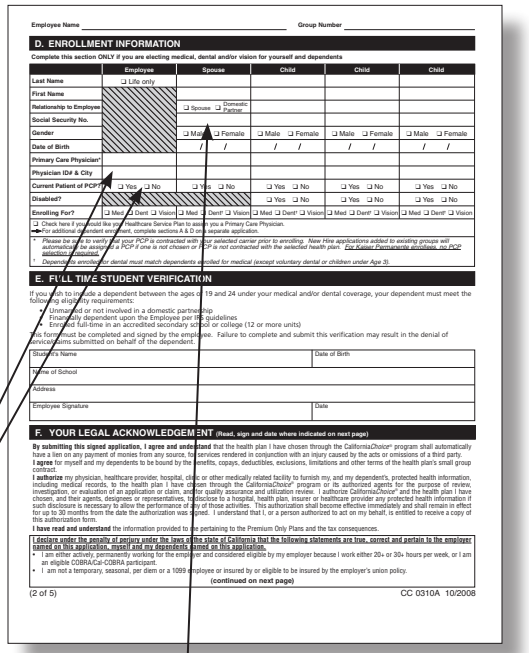
Your enrollment application will only take you a few minutes to complete. We recommend that once your application is completed that you go over it one last time to make sure all of the required fields are completed.

In addition to the Employee Enrollment Application, groups with 2-14 enrolling employees must also complete the Enrollment Health Statement.



Select Marital Status

Include date of hire

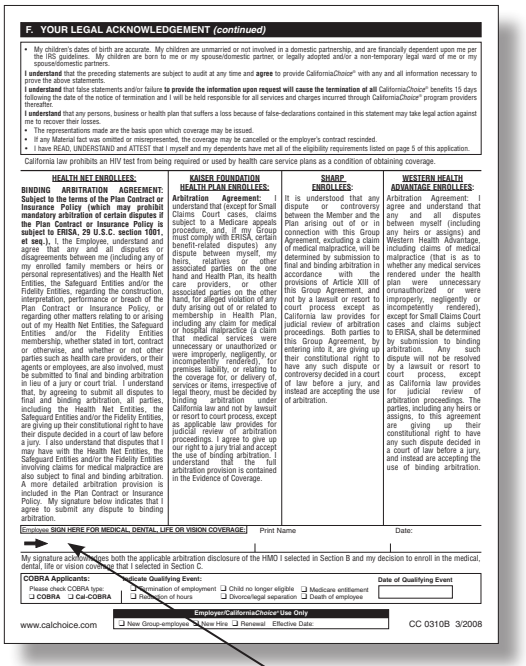


Include Social Security Numbers for dependents

Enter your Doctor's ID number and patient status

Frequently missed sections:

- Children's SSN
- Disabled dependent box
- Current Patient (if HMO)
- Dentist chosen (if DMO)
- Life beneficiary (if Life Insurance offered)
- Date of hire
- Marital status

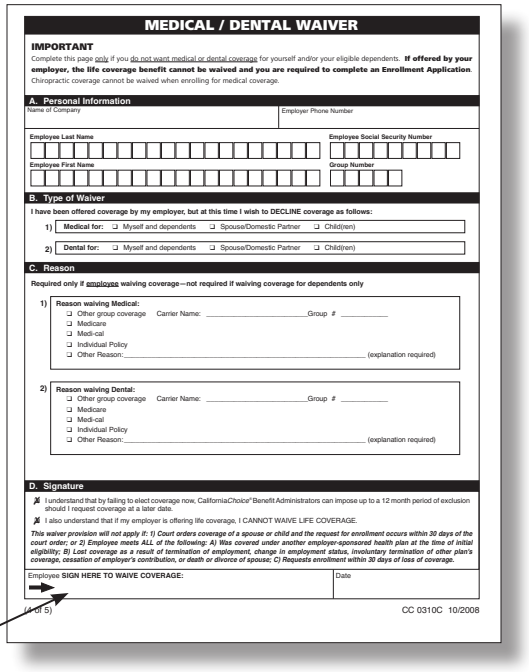


Sign Your Application

Sign here if you are accepting coverage

Waiver Form (attached to enrollment form)

By filling out a waiver, you're telling us that either you or one of your family members would like to waive coverage.



MEDICAL / DENTAL WAIVER

IMPORTANT

Complete this page only if you do not want medical or dental coverage for yourself and/or your eligible dependents. **If offered by your employer, the life coverage benefit cannot be waived and you are required to complete an Enrollment Application.** Chiropractic coverage cannot be waived when enrolling for medical coverage.

A. Personal Information

Name of Company | Employer Phone Number

Employee Last Name | Employee Social Security Number

Employee First Name | Group Number

B. Type of Waiver

I have been offered coverage by my employer, but at this time I wish to DECLINE coverage as follows:

1) **Medical for:** ❑ Myself and dependents ❑ Spouse/Domestic Partner ❑ Child(ren)

2) **Dental for:** ❑ Myself and dependents ❑ Spouse/Domestic Partner ❑ Child(ren)

C. Reason

Required only if employee waiving coverage—not required if waiving coverage for dependents only

1) **Reason waiving Medical:**
- ❑ Other group coverage Carrier Name: _____Group # _____
- ❑ Medicare
- ❑ Medi-cal
- ❑ Individual Policy
- ❑ Other Reason:_____ (explanation required)

2) **Reason waiving Dental:**
- ❑ Other group coverage Carrier Name: _____Group # _____
- ❑ Medicare
- ❑ Medi-cal
- ❑ Individual Policy
- ❑ Other Reason:_____ (explanation required)

D. Signature

✗ I understand that by failing to elect coverage now, California*Choice*® Benefit Administrators can impose up to a 12 month period of exclusion should I request coverage at a later date.

✗ I also understand that if my employer is offering life coverage, I CANNOT WAIVE LIFE COVERAGE.

This waiver provision will not apply if: 1) Court orders coverage of a spouse or child and the request for enrollment occurs within 30 days of the court order; or 2) Employee meets ALL of the following: A) Was covered under another employer-sponsored health plan at the time of initial eligibility; B) Lost coverage as a result of termination of employment, change in employment status, involuntary termination of other plan's coverage, cessation of employer's contribution, or death or divorce of spouse; C) Requests enrollment within 30 days of loss of coverage.

Employee **SIGN HERE TO WAIVE COVERAGE:** | Date

(4 of 5) CC 0310C 10/2008

Sign here if you are waiving coverage for yourself or any dependents

Important things to remember when waiving coverage:

- If you waive coverage for medical and/or buy-up dental benefits, you will have to wait for your company's renewal period to be eligible again.
- If you choose to enroll in medical and/or buy-dental benefits, but you want to waive an eligible spouse or dependent child, a waiver needs to be filled out.
- Please be sure to check-off the correct reason for waiving coverage.

Coverage for spouse and children

- If you are enrolled and have a spouse and/or children, they may also be eligible for coverage under your plan.

  SPOUSE: Must be legally married to you in order to be eligible for coverage through the California*Choice*® Program.

  CHILDREN: Eligible children include: children born to you, your stepchildren and your adopted children.

  Unmarried financially dependent children under age 19*, or unmarried children under age 25* who are full-time students at a qualified college, university, vocational or secondary school and who are fully supported by you can be covered under these benefit designs.

  Please note: A dependent child enrolled as a full-time student will not lose medical coverage because of a break in the school calendar or because he or she takes a medical leave of absence from school, for up to 12 months or until the date which the coverage is scheduled to terminate under the terms and conditions of the plan, whichever comes first. Physician Certification will be required and must be submitted within 30 days prior to the medical leave from school if the leave is foreseeable. If the leave is not foreseeable, the request must be submitted within 30 days of the medical leave from school.

  * Children incapable of self-support because of a continuous and pre-existing mental or physical disability are eligible for coverage until the incapacity ends. Documentation to prove disability may be requested.

- You are not required to extend coverage to either your spouse or your dependent children. If you do not wish to do so, you must check the appropriate boxes and sign the WAIVER Form, stating that you decline dependent coverage.
- Any family members enrolling for coverage through the California*Choice* Program must choose the same participating health plan and benefit design, although each is free to choose a different primary care physician.
- If you are in the middle of treatment AND your current physician is not contracted with the Health Plan you wish to select, please contact our Customer Service Center at 800.558.8003 for further information and assistance.

Domestic Partner Coverage

Requirements:

The employee and partner must fall into all of the following categories:

- Share a common residence
- Neither is married under either statutory, common law, or part of another domestic partnership
- Employee and Partner are both 18 years of age or older
- Share an intimate and committed relationship
- Employee and Partner agree to be jointly responsible for each other's basic living expenses incurred during the domestic relationship
- Mentally competent
- Not be related by blood to a degree of closeness that would prohibit marriage in this state
- Employee and Partner agree to notify California*Choice* immediately upon termination of domestic partnership

Members who are in a same sex partnership or are over the age of 62 are required to submit a state-stamped Certificate of Registration of Domestic Partnership from a state or local government agency authorized to perform such registrations within 30 days of issue; all others must submit a signed Affidavit of Domestic Partnership.

Formal proof of the required eligibility and existence of the relationship of the dependent to the Subscriber may be requested at the time of enrollment, service authorization request or claim submission.

Cal*Choice*® HMO 15, HMO 25, HMO 25 Value, Elect Open Access, Salud HMO y mas, Cal*Choice* HMO 30, HMO 30 Value, HMO 40 & HMO 40 Value

Summary of Benefit Exclusions & Limitations

Participating plans in the California*Choice*® Program WILL NOT cover the following items and/or circumstances:

- Hearing Aids.
- Chiropractic services.
- All non-emergency service and treatment not appropriately authorized by your participating health plan's requirements and not deemed medically necessary for the maintenance or improvement of health.
- Experimental medical, surgical or other healthcare procedures, products and medications which are classified by the U.S. Food and Drug Administration (FDA) except as required by the Knox-Keene Act regarding clinical trials for cancer, as experimental or restricted to investigative use. In the case of prescription drugs, a drug will be considered experimental if it has not been approved by the FDA or if the FDA has not approved the drug for specific indications, route of administration, or dosage involved.
- The purchase of eyeglasses or radial keratotomy.
- Custodial or domiciliary care, extended care, homemaker services or convalescent care not requiring skilled nursing care (even if prescribed or recommended by your Primary Care Physician).
- Dental services, except to prepare the jaw / jawbone for radiation therapy of neoplastic disease and medically necessary surgical procedures for conditions affecting the upper or lower jawbone or associated bone joints.
- Cosmetic surgery, except reconstructive to correct or repair abnormal structures of the body caused by congenital defects, development abnormalities, trauma, infection, tumors, or disease, if a healthcare service plan physician determines that it is necessary to improve function, or create a normal appearance, to the extent possible.
- In vitro fertilization, conception by artificial means, surrogate maternity services, and surgery for sex changes or to reverse previous surgery for voluntary sterilization and artificial insemination.
- Drug prescriptions from a non-participating pharmacy.

See *Evidence of Coverage* for a complete list of exclusions & limitations

AB 88 Mental Health Parity

- Health Plans that provide hospital, medical or surgical coverage must provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, and of serious emotional disturbances of a child, as specified, under the same terms and conditions applied to other medical conditions.
- These benefits will include in-patient, partial hospitalization and out-patient services and prescription drugs if the plan includes drug coverage.
- The mental health benefits must be applied the same as any other medical benefit including, but not limited to, maximum lifetime benefits, copays and individual and family deductibles.
- "Severe Mental Illness" includes: schizophrenic disorder, bipolar disorder (manic depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive development disorder or autism, anorexia nervosa and bulimia nervosa.

Cal*Choice*® PPO 750, PPO 1000, PPO 2400, HSA 1500, HSA 2400 and Active Choice℠ 500

Summary of Benefit Exclusions & Limitations

Unless specifically covered in the group's health service contract or as an optional benefit, no benefits are provided for:

- Services or procedures that are experimental or investigational in nature.
- Rest or custodial, maintenance or domiciliary care to control or change a patient's environment.
- Hospitalization or confinement primarily to treat or cure chronic pain, except as medically necessary.
- Rehabilitation or rehabilitative care.
- Services performed by house officers, residents, interns or others in training.
- Services performed by a close relative or by a person who ordinarily resides in the covered person's home.
- Hearing aids.
- Vocational, educational recreational, art, dance, music or reading therapy; weight control or exercise programs.
- Intersex surgery (except for medically necessary treatment of medical complications); sexual dysfunctions, sexual inadequacies (except for treatment of organically based conditions); artificial insemination, GIFT or in vitro fertilization.
- Infertility services incident to, or resulting from, procedures from a surrogate mother who is not a plan member eligible for maternity benefits.
- Penile implant devices or surgery, except as medically necessary.
- Routine foot care.
- Hyperkinetic syndrome, learning disability, behavioral problems, mental retardation or childhood autism.
- Organ transplants (except as specifically provided for in the contract).
- Cosmetic procedures.
- Patient convenience items.
- Injury or disease arising out of, or in the course of, any employment for salary, wage or profit if such injury or disease is covered by any Workers' compensation law, occupational disease law or similar legislation.
- In-patient psychiatric care.
- Eyeglasses, contact lenses, or surgery for refractive error (e.g., radial keratotomy).
- Dental services more than six months after accidental injury to teeth; for dental care or services incident to the treatment, prevention or relief of pain or dysfunction of the Temporomandibular Joint and/or muscles of mastication.
- Orthodontia and any service not listed as a benefit.
- Diagnosis and treatment of causes of infertility.
- Services for pre-existing conditions (for the first six months from the effective date of enrollment) unless you have prior credible coverage.
- Hospitalization primarily for x-ray, laboratory or diagnostic studies, or medical observation.

See *Evidence of Coverage* or Certificate of Insurance for a complete list of exclusions and limitations

If you have any questions regarding coverage through the California*Choice*® Program, including enrollment, please call the California*Choice* Customer Service Center at (800) 558-8003.

Blue Shield of California HMO (English)	(800) 424-6521	Kaiser Permanente (English)	(800) 464-4000
Blue Shield of California HMO (Spanish)	(800) 248-5451	Kaiser Permanente (Spanish)	(800) 788-0616
Blue Shield of California PPO	(800) 535-8000	Sharp Health Plan	(800) 359-2002
Health Net	(800) 361-3366	Western Health Advantage	(888) 563-2250

healthcare for the way we live®

800.558.8003
www.calchoice.com

CaliforniaChoice®
Your Health. Your Choice.®

A *CHOICE* Administrators® Program

CC0300.4.09.1