

THIS IS A HIGH LEVEL COMPARISON OF ALL PLANS INTRODUCED ON PAGES 4 & 5. Please note important exclusions and limitations on pages 10-13. Note this page is printed in English on one side and Spanish on the other; Chinese and Korean versions are available at [www.bluecrossca.com](http://www.bluecrossca.com) - ask your agent or call Customer Service for assistance (800) 627-8797.



Blue Cross of California (BCC) is a health care service plan regulated by the Department of Managed Health Care

# BenefIts from Blue Cross

## Plan Comparison & Overview



BC Life & Health (BCL&H) is an insurance company regulated by the Department of Insurance

Member pays all amounts unless noted.  
Amounts cover in-network services only; member pays more out-of-network.

	Hospital PPO Plans offered by BCL&H			Comprehensive PPO Plan offered by BCL&H	Comprehensive HMO Plan offered by BCC
	1 Hospital Benefits	2 Hospital Benefits Plus	3 Hospital Benefits Preferred	4 PPO \$35 Copay GenRx Plan	5 Power Select HMO Plan
<b>Lifetime Covered Charges Paid by Blue Cross</b>	<b>\$5,000,000</b>				<b>Unlimited</b>
Annual Deductible <i>Amount member pays first for covered services before plan benefits start; waived for some services</i>	\$1,250 per member (2 family member maximum*)	\$1,000 per member (2 family member maximum*)	\$750 per member (2 family member maximum*)	\$500 per member (2 family member maximum*)	\$500 per member
Annual Out-of-Pocket Maximum <i>The most a member pays in a year for qualified covered services before plan pays 100% for most in-network services</i>	Annual Deductible plus \$2,500			\$4,000 per member (includes deductible) (2 family member maximum*)	\$2,250 per member \$4,500 family aggregate* (includes deductible)
Prescription Drugs <i>Amounts shown are copays per 30-day supply</i>	\$15 - Generic Only				Generic: \$15 Brand: \$25 (after \$150 brand deductible)
Doctor Visits and Related Professional Services	No benefits	50% coinsurance for first \$1,000 of covered expenses and 100% after that (maximum Blue Cross payment of \$500 per year)	50% coinsurance for first \$1,500 of covered expenses and 100% after that (maximum Blue Cross payment of \$750 per year)	Doctor Visits: \$35 copay first 12 visits; then 45%  Professional Services including lab & maternity: 35%	Doctor Visits: \$25 copay Primary Care Physician; \$35 copay Specialist or Referral Care  Professional Services including lab & maternity: no charge
HealthyCheck <sup>SM</sup> Screening - Preventive health screenings; includes lab & immunizations	Choose \$25 or \$75 screening option				Not available
Inpatient Hospital Coverage	30% after deductible			35% after deductible	Facility: 10% Professional Services: no charge
Emergency Care <i>Member is also responsible for \$100 copay on <b>all</b> plans - waived if admitted</i>	30% after deductible			35% after deductible	\$100 Emergency Room copay - waived if admitted
Dental Coverage	None	None	2 free cleanings & up to \$500 benefit** after \$25 deductible	None	None
Vision Coverage	None	None	Up to \$100 benefit**	None	None

\* 2 family member maximum means that two covered members of the family must meet this amount *separately* to satisfy the requirement for all covered family members; aggregate means that all covered family members' eligible expenses can be *combined* to meet the family requirement.  
\*\* Dental and Vision benefit amounts cover Blue Cross payments for eligible expenses only as outlined in the Certificate.

**IMPORTANT: This overview should be used only for high level benefit comparisons using in-network providers; refer to the Summaries of Features, Certificates and/or Combined Evidence of Coverage and Disclosure Forms for comprehensive descriptions of coverage, benefits, special circumstances and limitations. Please note that In-network providers accept Blue Cross negotiated fee rates as payment in full for covered services. PPO plans: benefits listed are based on the negotiated fee rate for In-Network providers (Out-of-Network providers can charge more than the Negotiated Fee Rate); benefits listed are based on Customary and Reasonable charges (in cases of medical emergencies) for Out-of-Network providers; when members use an Out-of-Network provider, they must pay the applicable copayment or coinsurance, plus any charges that exceed that allowable amount.**

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