



CaliforniaChoice
Your Health. Your Choice.®

Health Plan Comparison Guide



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Physician Access & Referral

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QUESTIONS	Blue Shield of California HMO	Health Net HMO & ELECT Open Access (EOA)	Kaiser Permanente HMO	Sharp Health Plan
How often can my family members and I change Primary Care Physicians (PCP)?	Anytime	Once a month	Anytime	Anytime
Can each family member choose a different Primary Care Physician from different medical groups?	Yes	Yes	Yes—but only from Health Plan Physicians	Yes
Can I refer myself to a specialist? (For OB/GYN referral information, see pages 5 & 6)	Yes—if using Access+ HMO provider	HMO: Yes—if using a Rapid Access Provider ELECT Open Access: Yes—to any doctor in PPO network \$40 office visit copay	OB/GYN: Yes Other Specialties: Yes—to certain specialties. Self-refer specialties list varies by geographical region	Yes—if using a direct access medical group
Does the Health Carrier offer a program to help speed up the specialist referral process?	Yes—if using Access+ HMO provider	HMO: Yes—some Rapid Access Providers offer express referrals ELECT Open Access: Yes—member may self-refer to any doctor in PPO network—\$40 copay	Yes—referrals come directly from PCP; no other approval is needed	Yes—if available through medical group
Are dependents who live out-of-area covered?	Yes—please call 1-800-622-9402 to find out if the out-of-state Blue Shield plan where the dependents live participates in the Away From Home Care	Yes—only if a full-time student who maintains a permanent residence within Health Net's California Service Area for urgent and emergent services only	Yes—only if a student who maintains a permanent residence within Kaiser Permanente's service area. Students will be covered for emergencies only when outside of service area	Yes—only if a full-time student who maintains a permanent residence within Sharp Health Plan's Service Area

CaliforniaChoice HMO 10, 25 and 40 members may go to an Urgent Care Facility contracted through their medical group (PMG) or Individual Practice Association (IPA) for the same copay as their Primary Care Physician (PCP) office visit copay. Please contact your selected PMG or IPA to find out if they contract with an Urgent Care Facility and where it is located, so you will have this information handy when needed.

Physician Access & Referral



Universal Care & ChampionHEALTH	Western Health Advantage	Blue Shield PPO			
		PPO 500 & 1000	PPO 2400	Active Choice SM 500	HSA 2400
Universal Care Network: Once a month Champion Network: Upon request	Once a month	Anytime—In a PPO, you do not have to choose a PCP	Anytime—In a PPO, you do not have to choose a PCP	Anytime—In a PPO, you do not have to choose a PCP	Anytime—In a PPO, you do not have to choose a PCP
Yes	Yes	Yes—Each family member can make their own physician choice	Yes—Each family member can make their own physician choice	Yes—Each family member can make their own physician choice	Yes—Each family member can make their own physician choice
Universal Care Network: No Champion Network: No	Yes—to an ophthalmologist only, for your annual eye exam	Yes—In a PPO, you can choose any physician	Yes—In a PPO, you can choose any physician	Yes—In a PPO, you can choose any physician	Yes—In a PPO, you can choose any physician
Universal Care Network: No Champion Network: Yes	Yes—Advantage Referral Program allows PCP to refer member to any specialist in the WHA network	Yes—in a PPO, you don't have to go through a specialist referral process	Yes—in a PPO, you don't have to go through a specialist referral process	Yes—in a PPO, you don't have to go through a specialist referral process	Yes—in a PPO, you don't have to go through a specialist referral process
Yes—full-time student dependents outside of the service area are covered for emergency and urgently needed services only	Yes—full-time student dependents outside of the service area are covered for emergency and urgently needed services only	Yes	Yes	Yes	Yes

Note: All HMO benefits are covered in-network only

All CaliforniaChoice Health Plans cover life threatening emergencies anywhere in the world

Well Woman & Infertility Benefits

www.calchoice.com

QUESTIONS	Blue Shield of California HMO	Health Net HMO & ELECT Open Access (EOA)	Kaiser Permanente HMO	Sharp Health Plan
Can a member self-refer to an OB/GYN?	Yes—if OB/GYN is in the same medical group* or IPA* as your PCP	<u>HMO:</u> Yes—OB/GYN must be in same medical group* or IPA* as your PCP <u>ELECT Open Access:</u> Yes	Anytime	Yes—on an unlimited basis if OB/GYN is in the same medical group* or IPA* as your PCP
How often does health carrier allow a <u>routine</u> PAP smear?	Once a year†	Annually	Annually	Annually†
How often does health carrier allow a <u>routine</u> Mammogram?	Once a year†	<u>Ages 35-39:</u> One mammogram <u>Ages 40-49:</u> Every two years <u>Ages 50+ over:</u> Every year	As recommended by Health Plan Physician	Annually†
Does the carrier cover oral contraceptives?	Yes	Yes	Yes	Yes

† Or as recommended by the U.S. Preventive Services Task Force or the American College of Obstetricians and Gynecologists.

* A Medical Group or PMG consists of a group of physicians who are in partnership. The Medical Group makes referrals to specialists and handles its own administration.

An IPA is an Individual Practice Association, made up of a group of physicians who practice in their own separate offices but are part of a central administrator that oversees referrals and other HMO issues. Ask your PCP for the name of the IPA or medical group to which he or she belongs.

Well Woman & Infertility Benefits



Universal Care & ChampionHEALTH	Western Health Advantage	Blue Shield PPO			
		PPO 500 & 1000	PPO 2400	Active Choice SM 500	HSA 2400
Yes—anytime if OB/GYN is in the same PMG/IPA as your PCP	Yes—anytime to an OB/GYN in the WHA network	In a PPO, you can choose any OB/GYN anytime	In a PPO, you can choose any OB/GYN anytime	In a PPO, you can choose any OB/GYN anytime	In a PPO, you can choose any OB/GYN anytime
Annually—as recommended by the U.S. Preventative Services Task Force	Annually	Once a year	Once a year	Once a year	Once a year
<u>Ages 40-49:</u> every two years <u>Ages 50-69:</u> every year	<u>Ages 35-39:</u> one during five year period <u>Ages 40 & over:</u> one every calendar year	Once a year	Once a year	Once a year	Once a year
Yes—subject to the Universal Care Drug Formulary	Yes	Yes	Yes	Yes	Yes

Infertility Treatment:

After you are approved for coverage, you can call your health carrier directly to determine what infertility procedures are covered.

All cases are reviewed on a case-by-case basis

Prescription Drug Benefits

www.calchoice.com

QUESTIONS	Blue Shield of California HMO	Health Net HMO & ELECT Open Access (EOA)	Kaiser Permanente HMO	Sharp Health Plan																																																		
If generic drug is available and doctor has not indicated “dispense as written,” will member receive a generic equivalent rather than the brand name drug?	Yes—or you must pay the generic copay plus the difference in cost between the brand name & generic equivalent	Yes—or you must pay the brand copay plus the difference in cost between the brand name & generic equivalent	Yes	Yes—or you must pay the Non-Formulary copay																																																		
If doctor writes “dispense as written” on prescription, is brand name available at the brand copay?	Yes	Yes	Yes	Yes																																																		
If doctor writes a prescription and there is no generic available, will member receive brand name drug at generic copay?	No—brand name dispensed at brand name copay	No—brand name dispensed at brand name copay	No—brand name dispensed at brand name copay	No—brand name dispensed at brand name copay																																																		
What are my prescription copays for formulary drugs?	<table border="1"> <tr> <th>Generic</th> <th>Brand</th> </tr> <tr> <td>HMO CalChoice 10: \$10</td> <td>\$20</td> </tr> <tr> <td>HMO CalChoice 25: \$15</td> <td>\$25</td> </tr> <tr> <td>HMO CalChoice 40: \$20</td> <td>\$35</td> </tr> </table> <p>Home self-injectable[†] (excluding insulin): 20% contract rate—max. \$100/prescription</p>	Generic	Brand	HMO CalChoice 10: \$10	\$20	HMO CalChoice 25: \$15	\$25	HMO CalChoice 40: \$20	\$35	<table border="1"> <tr> <th>Generic</th> <th>Brand</th> </tr> <tr> <td>\$10</td> <td>\$20</td> </tr> <tr> <td>\$15</td> <td>\$25</td> </tr> <tr> <td>\$20</td> <td>\$35</td> </tr> </table> <p>All plans: self-injectables are subject to 30% coinsurance</p>	Generic	Brand	\$10	\$20	\$15	\$25	\$20	\$35	<table border="1"> <tr> <th>Generic</th> <th>Brand</th> </tr> <tr> <td>\$10</td> <td>\$20</td> </tr> <tr> <td>\$10</td> <td>\$25</td> </tr> <tr> <td>\$10</td> <td>\$30</td> </tr> </table>	Generic	Brand	\$10	\$20	\$10	\$25	\$10	\$30	<table border="1"> <tr> <th>Generic</th> <th>Brand</th> </tr> <tr> <td>\$10</td> <td>\$20</td> </tr> <tr> <td>\$15</td> <td>\$25</td> </tr> <tr> <td>\$20</td> <td>\$35</td> </tr> </table>	Generic	Brand	\$10	\$20	\$15	\$25	\$20	\$35																		
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The copayment shall be the designated amount, or 50% of the provider’s contract rate, whichever is less																																																						
Are Non-Formulary drugs covered?	Yes—if medically necessary and pre-approved. Standard HMO copays apply (see above)	Yes—HMO 10 & EOA: \$50 Non-Formulary copay applies HMO 25 & Salud: \$50 Non-Formulary copay applies HMO 40: \$50 Non-Formulary copay applies Prior authorization may be required for certain medications	Yes—if deemed medically necessary by Health Plan Physician	Yes—copay is double the brand copay. Prior authorization may be required for certain medications																																																		
Mail Order	<table border="1"> <tr> <th colspan="2">90 Day Supply:</th> </tr> <tr> <th>Generic</th> <th>Brand</th> </tr> <tr> <td>HMO CalChoice 10: \$20</td> <td>\$40</td> </tr> <tr> <td>HMO CalChoice 25: \$30</td> <td>\$50</td> </tr> <tr> <td>HMO CalChoice 40: \$30</td> <td>\$70</td> </tr> </table> <p>No mail order benefit for Non-Formulary</p>	90 Day Supply:		Generic	Brand	HMO CalChoice 10: \$20	\$40	HMO CalChoice 25: \$30	\$50	HMO CalChoice 40: \$30	\$70	<table border="1"> <tr> <th colspan="3">90 Day Supply:</th> </tr> <tr> <th>Generic</th> <th>Brand</th> <th>Non-Formulary</th> </tr> <tr> <td>\$20</td> <td>\$40</td> <td>\$100</td> </tr> <tr> <td>\$30</td> <td>\$50</td> <td>\$100</td> </tr> <tr> <td>\$40</td> <td>\$70</td> <td>\$100</td> </tr> </table> <p>EOA: \$30 \$50 \$100 All plans: self-injectables are subject to 30% coinsurance</p>	90 Day Supply:			Generic	Brand	Non-Formulary	\$20	\$40	\$100	\$30	\$50	\$100	\$40	\$70	\$100	<table border="1"> <tr> <th colspan="2">Up To A 100 Day Supply:</th> </tr> <tr> <th>Generic</th> <th>Brand</th> </tr> <tr> <td>\$20</td> <td>\$40</td> </tr> <tr> <td>\$20</td> <td>\$50</td> </tr> <tr> <td>\$20</td> <td>\$60</td> </tr> </table> <p>No mail order benefit for Non-Formulary</p>	Up To A 100 Day Supply:		Generic	Brand	\$20	\$40	\$20	\$50	\$20	\$60	<table border="1"> <tr> <th colspan="3">90 Day Supply:</th> </tr> <tr> <th>Generic</th> <th>Brand</th> <th>Non-Formulary</th> </tr> <tr> <td>\$20</td> <td>\$40</td> <td>\$80</td> </tr> <tr> <td>\$30</td> <td>\$50</td> <td>\$100</td> </tr> <tr> <td>\$40</td> <td>\$70</td> <td>\$140</td> </tr> </table>	90 Day Supply:			Generic	Brand	Non-Formulary	\$20	\$40	\$80	\$30	\$50	\$100	\$40	\$70	\$140
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† For the Blue Shield HMO plans, Home Self-Administered Injectable Medications will be limited to Specialty Pharmacies contracted by Blue Shield to provide covered Home Self-Administered Injectables. Member pays 20% of allowed charges (up to a \$100 copayment maximum per prescription). Prior authorization may be required.

*What does “formulary” mean?

An Rx formulary is an approved list of drugs which have been reviewed for safety, quality, effectiveness and cost by the physicians and pharmacists on a Healthcare Service Plan’s Rx review panel. A Non-Formulary drug refers to a drug which is not included on the approved Rx list for a Healthcare Service Plan and is not excluded by the Healthcare Service Plan’s Evidence Of Coverage (EOC). Please refer to your EOC for Rx coverage details. Each Healthcare Service Plan has their own formulary or approved drug list which is reviewed on a regular basis.

Universal Care & ChampionHEALTH	Western Health Advantage	Blue Shield PPO																																														
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Brand name drug that has a generic equivalent needs to be prior authorized to be covered at the Brand copayment. Otherwise, the Non-Formulary copayment applies	Yes—or you must pay the brand copay plus the difference in cost between the brand name & generic equivalent	Yes—or you must pay the generic copay plus the difference between the cost of the brand name & generic ¹	Yes—or you must pay the generic copay plus the difference between the cost of the brand name & generic ¹	Yes—or you must pay the generic copay plus the difference between the cost of the brand name & generic ¹	A 20% copay applies to brand name and generic after paying the deductible*																																											
Yes—if prior authorized	Yes	Yes ¹	Yes ¹	Yes ¹	A 20% copay applies to brand name and generic after paying the deductible*																																											
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Yes—prior authorization may be required for certain medications. 50% Non-Formulary copay per prescription applies	Yes CC 10: \$35 CC 25: \$40 CC 40: \$50	<p>Participating Pharmacy:¹ \$45</p> <p>Non-Participating Pharmacy: \$45 + 25%</p> <p>PPO 500: \$125 per individual brand deductible applies PPO 1000: \$150 per individual brand deductible applies</p>	<p>Participating Pharmacy:¹ \$45</p> <p>\$200 per individual brand deductible applies</p> <p>Non-Participating Pharmacy: Not Covered</p>	<p>Participating Pharmacy:¹ \$45 or 50% whichever is greater</p> <p>\$500 per individual brand deductible applies</p> <p>Non-Participating Pharmacy: Not Covered</p>	<p>Participating Pharmacy: Member pays 20% of network discount rate*</p> <p>Non-Participating Pharmacy: Member pays 20%*</p>																																											
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* Prescription Drugs are subject to the medical deductible. The submission of a prescription drug claim is required for reimbursement of all outpatient prescription drugs

¹ For the Blue Shield PPO plans (except the HSA 2400 plan), Home Self-Administered Injectable Medications are limited to Specialty Pharmacies contracted by Blue Shield to provide covered Home Self-Administered Injectables. Member pays 30% and prior authorization may be required. The Brand Rx deductible will apply.

Diabetes Benefits



A reminder from the National Diabetes Education Program, a Joint Program of the National Institutes of Health and the Centers for Disease Control and Prevention

QUESTIONS	Blue Shield of California HMO	Health Net HMO & ELECT Open Access (EOA)	Kaiser Permanente HMO	Sharp Health Plan
Insulin	Covered under the Prescription Drug Benefit	Covered under the Prescription Drug Benefit	Covered under the Prescription Drug Benefit	Covered under the Prescription Drug Benefit
Needles/Syringes	Covered under the Prescription Drug Benefit	Covered under the Prescription Drug Benefit	Covered under the Prescription Drug Benefit	Covered as Durable Medical Equipment, rather than Prescription Drug Benefit: CalChoice 10-90% CalChoice 25-70% CalChoice 40-50%
Glucose Monitor	Covered as Durable Medical Equipment, rather than Prescription Drug Benefit: CalChoice 10-90% CalChoice 25-70% CalChoice 40-50%	Covered as Durable Medical Equipment, rather than Prescription Drug Benefit: CalChoice 10-90% CalChoice 25-80% CalChoice 40-80%	Covered as Durable Medical Equipment, rather than Prescription Drug Benefit: CalChoice 10-100% CalChoice 25-80% CalChoice 40-80% up to \$2500 max./calendar year	Covered as Durable Medical Equipment rather than Prescription Drug Benefit
Chem-Strips and/or Testing Agents	Covered under the Prescription Drug Benefit	Covered under the Prescription Drug Benefit	Covered under the Prescription Drug Benefit	Covered as Durable Medical Equipment rather than Prescription Drug Benefit
Insulin Pump	Covered as Durable Medical Equipment rather than Prescription Drug Benefit	Covered as Durable Medical Equipment, rather than Prescription Drug Benefit: CalChoice 10-90% CalChoice 25-80% CalChoice 40-80%	Covered as Durable Medical Equipment rather than Prescription Drug Benefit	Covered as Durable Medical Equipment rather than Prescription Drug Benefit
Insulin Pump Supplies	Covered as Durable Medical Equipment rather than Prescription Drug Benefit	Covered as Durable Medical Equipment, rather than Prescription Drug Benefit: CalChoice 10-90% CalChoice 25-80% CalChoice 40-80%	Covered as Durable Medical Equipment rather than Prescription Drug Benefit	Covered as Durable Medical Equipment rather than Prescription Drug Benefit

Diabetes Benefits



Universal Care & ChampionHEALTH	Western Health Advantage	Blue Shield PPO			
		PPO 500 & 1000	PPO 2400	Active Choice SM 500	HSA 2400
Covered under the Prescription Drug Benefit	Covered under the Prescription Drug Benefit	Covered under the Prescription Drug Benefit	Covered under the Prescription Drug Benefit	Covered under the Prescription Drug Benefit	Covered under the Prescription Drug Benefit
Covered under the Prescription Drug Benefit	Covered under the Prescription Drug Benefit	Covered under the Prescription Drug Benefit	Covered under the Prescription Drug Benefit	Covered under the Prescription Drug Benefit	Covered under the Prescription Drug Benefit
Glucometers are available, at no cost to all Universal Care members who have Type I or Type II diabetes	Covered as Durable Medical Equipment, rather than Prescription Drug Benefit: CalChoice 10-90% CalChoice 25-70% CalChoice 40-50%	Covered as Durable Medical Equipment (Medical Deductible applies) PPO 500: In-Network: 80% Out-of-Network: 60% PPO 1000: In-Network: 50% Out-of-Network: 50%	Covered as Durable Medical Equipment (Medical Deductible applies) In-Network: 50% Out-of-Network: Not Covered	In or Out-of-Network: 100% up to \$500/\$1000 [†]	Covered as Durable Medical Equipment (Medical Deductible applies) In-Network: 80% Out-of-Network: 50%
Covered under the Prescription Drug Benefit	Covered under the Prescription Drug Benefit	Covered under the Prescription Drug Benefit	Covered under the Prescription Drug Benefit	Covered under the Prescription Drug Benefit	Covered under the Prescription Drug Benefit
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[†] After the first \$500 (individual), \$1000 (family) 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

Additional Benefits

Family Health Programs

The key to a fulfilling life is staying healthy, and educating yourself about illness when it does occur so you can take the proper steps. All of the health plans in CaliforniaChoice offer programs on the following topics via participating Medical Groups or IPAs to help you make an informed decision:

Breast Health	Diabetes
Asthma/Respiratory Problems	High Blood Pressure
Baby Care	Materials in Spanish
Breastfeeding	Parenting/Expectant Father
Cancer	Stop Smoking
Childbirth	Weight Loss Management

NOTE: Not all programs will be available at all Medical Groups and IPAs

24-Hour Nurse Hotline

These carriers provide a staff of nurses to help you find answers when things go bump in the night or to deal with minor situations anytime:

Blue Shield of California*
(866) LIFEPATH

Kaiser Permanente
Nurse Hotline varies by geographical region. Please contact Member Services for Nurse Hotline number in your area:
English (800) 464-4000
Spanish (800) 788-0616

Sharp Health Plan
(800) 359-2002

Universal Care & ChampionHEALTH
(800) 377-7012

*Blue Shield of California HMO or PPO members may speak with a master's level counselor about personal or emotional issues, elder care, child/family care or legal/financial issues anytime by calling the Lifepath Advisers™ number: (866) LIFEPATH

Other Health Programs

In addition, many health plans feature programs for your family on other important topics:

	Blue Shield PPO	Blue Shield HMO & Elect. Open Access	Kaiser Permanente HMO	Health Net	Western Health Advantage Sharp	Universal Care & ChampionHEALTH
Back Injury Prevention	★	★	★		★	
Back Pain Management	★	★	★	★	★	★
CPR	★	★			★	★
Eating Disorders	★	★	★	★		★
Family Planning	★	★		★	★	★
First Aid	★	★			★	★
Grief Recovery	★	★		★	★	★
Headaches				★		
Health Books	★	★		★		★
Home and/or Child Safety	★	★		★	★	★
Infant Car Seat Award			★*			
Infant Car Seat Discount			★			★
Prostate Problems	★	★	★	★		
Stress Management	★	★	★	★	★	★

*Upon prenatal class completion.

NOTE: Not all programs will be available at all Medical Groups and IPAs. Please contact your selected Medical Group or IPA for details regarding their specific program offerings.

Health Plan Accreditation Status



What is NCQA Accreditation?

NCQA stands for the National Committee for Quality Assurance, a not-for-profit organization that evaluates how well a Healthcare Service Plan manages its clinical and administrative systems in order to improve health care quality for its members.

An NCQA team of physicians and managed care experts conducts rigorous on and off site evaluations. A national oversight committee – made up of physicians – analyzes the team's findings and assigns an Accreditation level based on the plan's performance compared to NCQA standards. NCQA has purposely set high standards to encourage Healthcare Service Plans to enhance their quality. Below are the latest ratings from the NCQA for health plans participating in CaliforniaChoice.

The following HMOs have an "Excellent" rating from the NCQA for their commercial products:

- Blue Shield of CA
- Health Net
- Kaiser Permanente
- Universal Care
- Western Health Advantage



Answers to Frequently Asked Questions

What is an HMO?

Members receive medical services through contracted physicians and hospitals. Nominal copayments are paid for office visits, prescription drugs and other covered services. There are no waiting periods for treatment of pre-existing conditions on covered services.

What is a PPO?

Members can choose to receive care through either a network or non-network provider. If care is received through a network provider, fees are based on a negotiated discounted basis. Unlike an HMO, PPOs do not require the selection of a Primary Care Physician to direct care. Waiting periods may be required for some services for pre-existing conditions.

What is ELECTSM Open Access?

Health Net ELECTSM Open Access will appeal to both HMO and PPO buyers. This plan allows you to choose a Primary Care Physician (PCP) who will coordinate all your care and treat you for many medical conditions with a low \$25 copay for office visits. For a \$40 copayment you may self-refer to any doctor or specialist in the Health Net PPO network of over 48,000 physicians.

What is an HSA Self-Directed Plan?

The PPO 2400 can provide a financial planning approach to managing the cost of healthcare. This low premium, high deductible plan is compatible with an HSA. It is designed to encourage the participant to take control of their healthcare decisions by building a reserve to fund first dollar medical costs.

What is a Primary Care Physician (PCP)?

The HMO doctor who coordinates all your health care and medical needs, including basic care, referrals to specialists and hospitalization arrangements. Primary Care Physicians are identified in your CaliforniaChoice Provider Directory with a circle.

What is an IPA or Medical Group?

An IPA – or Individual Practice Association – is a group of physicians and other individual providers who practice in their own separate offices but are part of a central administrator that oversees referrals and other issues regarding HMOs. A Medical Group also provides your referrals but the doctors are in partnership.

What is a copayment?

This is the amount you and/or your dependents must pay for medical services (i.e. doctor visits, drug prescriptions, hospitalizations, etc.).

Why do Healthcare Service Plan premiums differ so greatly?

Each Healthcare Service Plan has its own philosophy on delivering medical care. Doctor's networks, specialist referral policies, consumer education, available prescription drugs and preventive health programs differ from plan to plan. That's why it's important for you to compare each plan on the things that are important to you.

Answers to Frequently Asked Questions

What if I receive a bill?

Although you should not receive bills for HMO medical care provided or approved by your Primary Care Physician, you may receive a bill in error. If you receive a bill, contact your health plan's Member Services Department for assistance, or call CaliforniaChoice Member Services at (800) 558-8003.

How often can I change my Primary Care Physician?

HMOs are very flexible in this regard. However, each CaliforniaChoice Healthcare Service Plan has different policies. It's best to refer to the comparison chart on pages 3 and 4 of this brochure.

Can each family member choose a different benefit design and Healthcare Service Plan?

All family members must select the same benefit design and the same Healthcare Service Plan.

How often can my family and I change our benefit level and Healthcare Service Plan?

You and each of your dependents may change your benefit level and Healthcare Service Plan once a year at Open Enrollment.

Can I add family members after my initial enrollment?

New family members may be added within 30 days of birth, adoption placement or marriage. Eligible dependents may be added at your group's annual Open Enrollment.

What if I have an emergency situation?

If the emergency is life threatening, such as a heart attack, or is critically serious, such as a broken leg, go directly to the nearest hospital. However, you (or a family member) must contact your Primary Care Physician within 24 hours. If you are unable to get in touch with your Primary Care Physician, contact the Healthcare Service Plan Member Services number.

Do any Healthcare Service Plans offer self-referrals or expedited referrals to specialists?

All of our PPO Healthcare Service Plans are completely self-referral. Prior authorization is only required for some procedures.

All of our HMO Healthcare Service Plans offer self-referral to an OB/GYN in the same IPA or medical group as your Primary Care Physician (PCP). Many of our HMO Healthcare Service Plans also offer self-referrals and/or an "express" system to speed referrals for other specialists. (Please see comparison chart on pages 3 and 4 of this brochure.)

Please see your Healthcare Service Plan's Evidence of Coverage document for detailed information on the various limitations, exclusions and conditions concerning benefits and program regulations.





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Your Health. Your Choice.®

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