

Blue Lake Rancheria Health Plan
Effective January 1, 2007

Annual Deductible Individual: \$500 Family: \$1,000
 Lifetime Maximum Plan Benefit \$1,000,000 per member
 Annual Maximum Plan Benefit Individual: \$50,000 Family: \$120,000
 Annual Out of Pocket Maximum None
 Networks Humboldt Del Norte IPA (local), California Foundation for Medical Care (state), and Plan Vista (national)

Medical Services	In-Network Coverage	Out-of-Network Coverage	Comments
Physician/Podiatrist Care – Office services	\$30 co-pay for primary care \$40 co-pay for specialty care	60% of IPA contract allowable after deductible 60% of IPA contract allowable after deductible	See Preventive Care for services not related to injury or sickness.
Physician/Podiatrist - Inpatient/Outpatient services	80% after deductible	60% of IPA contract allowable after deductible	Weight loss surgery not covered.
Preventive Care	100% up to \$1,000 per year	100% up to \$1,000 per year	Visits, pap, mammogram, sigmoidoscopy, immunizations.
Laboratory - all outpatient locations	\$15 co-pay, then 100%	Not Covered	Co-pay waived if provided with office visit.
X-ray	\$30 co-pay, then 100%	60% of IPA contract allowable after deductible	Co-pay waived if provided with office visit.
Hospital - Emergency	80% after deductible	80% of IPA contract allowable after deductible	
Hospital - Inpatient service available at MRCH	Lesser of 80% or MRCH contract	n/a	
Hospital - Inpatient service NOT available at MRCH	80% after deductible	60% of IPA contract allowable after deductible	
Hospital - Outpatient	80% after deductible	60% of IPA contract allowable after deductible	
Hospital - Urgent Care	80% after deductible	60% of IPA contract allowable after deductible	
Durable Medical Equipment	80% after deductible	60% of IPA contract allowable after deductible	
All other services not mentioned	80% after deductible	60% of IPA contract allowable after deductible	
Mental Health	No coverage		
Rehabilitation Services - Combined Benefit			
Acupuncture/Acupressure	\$30 co-pay	60% after deductible	Annual combined plan benefit of \$1,000.
Chiropractic Services	\$30 co-pay	60% of IPA contract allowable after deductible	Includes x-rays and all modalities of care.
Physical/Occupational, Speech Therapy	\$30 co-pay	60% of IPA contract allowable after deductible	No pre-authorization required.
Dental Services			
Annual Deductible	\$50 per covered person		
Annual Maximum Plan Benefit	\$1,500 per covered person		
Preventive Care	Plan pays 100%		
Basic Services	Plan pays 80%		
Major Services	Plan pays 50%		
Prescription Services	Retail Co-Pays (30 day supply)	Mail-Order Co-Pays (90 day supply)	Comments
Administered by HealthTrans at 877-839-8119	\$10 generic	\$20 generic	No deductible
Annual Maximum Plan Benefit: \$5,000 per covered person	\$40 preferred brand name \$70 non-preferred brand name	\$80 preferred brand name \$140 non-preferred brand name	
Vision Services	In-Network Coverage	Out-of-Network Coverage	Comments
Administered by Vision Services Plan at 800-877-7195			