P.O Box 60007
Los Angeles, CA 90060

Maximum Copayment Liability Notification

Dear Blue Cross HMO Member:

Co-payments may be required for certain authorized services as indicated in your Evidence of Coverage. Blue Cross HMO limits the amount of co-payments you and your family members must pay during one calendar year. This is called your "Maximum Co-Payment Liability"

The maximum Co-Payment Liability for your Blue Cross HMO Plan is indicated in your Evidence of Coverage for the calendar Year _____ (fill in appropriate year) Select the maximum liability applicable to your type of contract. (If you change contract types during the year, e.g. change from a single to a two-party contract, co-payments made under the previous contract will apply toward your maximum under the new one)

Use the bottom portion of this form to record co-payments you have paid during the year for services provided to you and members of your family. It is your responsibility to maintain records to validate when your Maximum Co-Payment Liability is reached. Attach all receipts or cancelled checks for these co-payments to this form. Please refer to your Blue Cross HMO Evidence of Coverage for services included or not included (i.e. prescription drug co-payments, noncovered services do not apply to co-payment maximum liability) As soon as you reach your maximum for the year, fill out the member information requested below and mail a copy of this form and proof of payment to the address above.

MEMBER LAST FIRST MIDDLE	MEMBER ADDRESS	
MEMBER'S PARTICIPATING MEDICAL GRP	CERTIFICATE NUMBER	GROUP

DATE OF SERVICE	PATIENT'S NAME	PROVIDER OF SERVICE (HOSP, DOCTOR, LAB, AMBUL, RN)	ILLNESS OR DIAGNOSIS	DESCRIPTION OF SERV RENDERED	COPAYMENT
				GRAND TOTAL	

(Use additional pages if necessary)

MAX-CO.FRM 04/08

Registered Mark of the Blue Cross Association