

**Proposed Benefit Summary**

**100096 SAN BERNARDINO COMMUNITY COLLEGE DISTRICT - DUALOPTION \$40 HI COPAY PLAN**

**Principal Benefits for High Copay HMO SCR (4/1/10—6/30/11)**

The Services described below are covered only if all the following conditions are satisfied:

- The Services are Medically Necessary
- The Services are provided, prescribed, authorized, or directed by a Plan Physician and you receive the Services from Plan Providers inside our Southern California Region Service Area (your Home Region), except where specifically noted to the contrary in the *Evidence of Coverage (EOC)* for authorized referrals, hospice care, Emergency Care, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

**Annual Out-of-Pocket Maximum for Certain Services**

For Services subject to the maximum, you will not pay any more Cost Sharing during a calendar year if the Copayments and Coinsurance you pay for those Services add up to one of the following amounts:

For self-only enrollment (a Family of one Member).....	\$3,000 per calendar year
For any one Member in a Family of two or more Members .....	\$3,000 per calendar year
For an entire Family of two or more Members .....	\$6,000 per calendar year

**Deductible or Lifetime Maximum** None

**Professional Services (Plan Provider office visits)** You Pay

Routine preventive care:

Physical exams .....	\$40 per visit
Well-child visits (through age 23 months) .....	\$10 per visit
Family planning visits .....	\$40 per visit
Scheduled prenatal care visits and first postpartum visit .....	\$10 per visit
Eye exams for refraction .....	\$40 per visit
Hearing tests .....	\$40 per visit
Flexible sigmoidoscopies .....	\$40 per visit

Primary and specialty care visits .....

Urgent care visits.....

Voluntary termination of pregnancy.....

Physical, occupational, and speech therapy .....

**Outpatient Services** You Pay

Outpatient surgery and certain other outpatient procedures .....

Allergy injection visits .....

Allergy testing visits .....

Most vaccines (immunizations) .....

X-rays and lab tests.....

MRI, CT and PET .....

Health education:

Individual visits .....

Group educational programs.....

**Hospitalization Services** You Pay

Room and board, surgery, anesthesia, X-rays, lab tests, and drugs .....

**Emergency Health Coverage** You Pay

Emergency Department visits .....

Note: This Cost Sharing does not apply if admitted directly to the hospital as an inpatient (see "Hospitalization Services" for inpatient Cost Sharing)

**Ambulance Services** You Pay

Ambulance Services .....

**Prescription Drug Coverage** You Pay

Most covered outpatient items in accord with our drug formulary guidelines:

Generic items from a Plan Pharmacy .....

Generic refills from our mail-order service .....

Brand-name items from a Plan Pharmacy .....

Brand-name refills from our mail-order service.....

continued

<b>Durable Medical Equipment</b>	<b>You Pay</b>
Covered durable medical equipment for home use in accord with our durable medical equipment formulary guidelines .....	50% Coinsurance
<b>Mental Health Services</b>	<b>You Pay</b>
Inpatient psychiatric hospitalization and intensive psychiatric treatment programs.....	\$500 per admission
Outpatient individual and group visits.....	\$40 per individual visit \$20 per group visit
<b>Chemical Dependency Services</b>	<b>You Pay</b>
Inpatient detoxification.....	\$500 per admission
Outpatient individual visits.....	\$40 per visit
Outpatient group visits.....	\$5 per visit
<b>Home Health Services</b>	<b>You Pay</b>
Home health care (up to 100 visits per calendar year) .....	No charge
<b>Other</b>	<b>You Pay</b>
Eyewear purchased from plan optical sales offices every 24 months.....	Amount in excess of \$300 Allowance
All covered Services related to infertility treatment .....	50% Coinsurance
Hospice care .....	No charge

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Sharing, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Sharing. For a complete explanation, please refer to the *EOC*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).