

Member Responsibility		HDHP 200
<b>General Benefits</b>		
Calendar Year Deductible	Individual: \$2,000 Family: \$6,000	
Coinsurance	20% After Deductible	
Calendar Year Out-of-Pocket Maximum	Individual: \$5,250 Family: \$10,050 (No family member will pay more than \$6,850 per calendar year.)	
<b>Doctor Visits</b>		
Doctor Visits (Primary Care)	20% After Deductible	
Doctor Visits (Specialists)	20% After Deductible	
Preventive Care/Immunizations	No Charge	
<b>Lab &amp; X-Ray</b>		
Outpatient Diagnostic Tests/Imaging	20% After Deductible	
Radiation Therapy Chemotherapy	20% After Deductible	
<b>Medical Benefits</b>		
Ambulance-Ground/Air	20% After Deductible	
Physical Therapy	20% After Deductible	
Acupuncture	20% After Deductible Max 12 Visits per calendar year	
Chiropractic	20% After Deductible	
Durable Medical Equipment	20% After Deductible	
<b>Hospital Benefits</b>		
Outpatient Surgery	20% After Deductible	
Hospital Inpatient	20% After Deductible/Semi Private Room Unlimited Days	
Hospital Emergency Room	20% After Deductible	
Urgent Care	20% After Deductible	
Home Health Care	20% After Deductible 100 visits max per calendar year	
<b>Substance Abuse &amp; Mental Health Benefits</b>		
Teledoc-Medical Services	Teledoc - \$5 Call Copay 800-835-2362 or visit <a href="http://www.teledoc.com/bsc">www.teledoc.com/bsc</a> for Non-Emergency services	
Life Referrals 24/7 EAP	Visit <a href="http://blueshieldca.com">blueshieldca.com</a> or call 800-985-2405 for services	
Mental Health-Substance Abuse	Visit <a href="http://blueshieldca.com">blueshieldca.com</a> or call 877-263-9952 for services	
<b>Prescription Drug Benefits</b>		
Prescription Drugs-Generic	20% After Deductible (30 Day Supply)	
Prescription Drugs-Brand	20% After Deductible (30 Day Supply)	
Prescription Drugs-Non Preferred	20% After Deductible (30 Day Supply)	
Mail Order-Generic	20% After Deductible (90 Day Supply)	
Mail Order-Brand or Non Preferred	20% After Deductible (90 Day Supply)	