

Member Responsibility	PPO 100
General Benefits	
Calendar Year Deductible	Individual: \$100 Family: \$300
Coinsurance	10% After Deductible
Calendar Year Out-of-Pocket Maximum	Individual: \$1,500 Family: \$4,500
Doctor Visits	
Doctor Visits (Primary Care)	\$20 Copay
Doctor Visits (Specialists)	\$20 Copay
Preventive Care/Immunizations	No Charge
Lab & X-Ray	
Outpatient Diagnostic Tests/Imaging	10% After Deductible
Radiation Therapy Chemotherapy	10% After Deductible
Medical Benefits	
Ambulance-Ground/Air	10% After Deductible
Physical Therapy	10% After Deductible (Copay if applicable)
Acupuncture	Paid at 100% Max 12 Visits per calendar year (Copay if applicable)
Chiropractic	10% After Deductible (Copay if applicable)
Durable Medical Equipment	10% After Deductible
Hospital Benefits	
Outpatient Surgery	10% After Deductible
Hospital Inpatient	10% After Deductible/Semi Private Room Unlimited Days
Hospital Emergency Room	\$100 Copay (Waived if Admitted as Inpatient) 10% After Deductible
Urgent Care	\$20 Copay
Home Health Care	Paid at 100% 100 visits max per calendar year
Substance Abuse & Mental Health Benefits	
Teledoc-Medical Services	Teledoc - \$5 Call Copay 800-835-2362 or visit www.teledoc.com/bsc for Non-Emergency services
Life Referrals 24/7 EAP	Visit blueshieldca.com or call 800-985-2405 for services
Mental Health-Substance Abuse	Visit blueshieldca.com or call 877-263-9952 for services
Prescription Drug Benefits	
Prescription Drugs-Generic	\$10 Copay
Prescription Drugs-Brand	\$20 Copay
Prescription Drugs-Non Preferred	\$40 Copay
Mail Order-Generic	\$10 Copay
Mail Order-Brand or Non Preferred	\$40 Copay