

Member Responsibility	HDHP 100
General Benefits	
Calendar Year Deductible	Individual: \$1,300 Family: \$3,000
Coinsurance	20% After Deductible
Calendar Year Out-of-Pocket Maximum	Individual: \$4,250 Family: \$10,100 (No family member will pay more than \$6,850 per calendar year.)
Doctor Visits	
Doctor Visits (Primary Care)	20% After Deductible
Doctor Visits (Specialists)	20% After Deductible
Preventive Care/Immunizations	No Charge
Lab & X-Ray	
Outpatient Diagnostic Tests/Imaging	20% After Deductible
Radiation Therapy Chemotherapy	20% After Deductible
Medical Benefits	
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
Hospital Benefits	
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
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	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)