

Unity of Imperial – Management Only

Plan II

Benefit Summary

(Uniform Health Plan Benefits and Coverage Matrix)

Blue Shield of California

Effective July 1, 2008

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE, DISCLOSURE FORM AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

DEDUCTIBLES ¹ (Deductible waived for El Centro Regional Medical Center, Pioneers Memorial Hospital)	Preferred Providers ²	Non-Preferred Providers ²
Calendar-year medical deductible	\$500 per individual/\$1,000 per family	
Calendar-year Copayment Maximum ¹	\$4,000 per individual	\$8,000 per individual
LIFETIME MAXIMUMS	\$5,000,000	
Covered Services	Member Copayment	
PROFESSIONAL SERVICES	Preferred Providers ²	Non-Preferred Providers ²
Physician services		
• Physician and specialist office visits	20%	40% ¹
• Laboratory and X-rays	20%	40%
• Allergy testing or treatment	20%	40%
• Diagnostic testing	20%	40%
Preventive care¹⁰		
• Annual routine physical exam, eye/ear screenings and immunizations and vaccinations	20% (Deductible waived)	Not covered
• Laboratory, including mammogram and Pap test screening or other FDA-approved cervical cancer screening tests (One per calendar year)	20% (Deductible waived)	40%
Well-baby care¹⁰		
• Office visits and consultations Includes: eye/ear screenings, immunizations, vaccinations	20% (Deductible waived)	Not covered
• Laboratory (One per calendar year)	20% (Deductible waived)	40%
OUTPATIENT SERVICES		
The maximum allowed charges for non-emergency surgery and services performed in a non-participating Ambulatory Surgery Center or outpatient unit of a non-preferred hospital is \$3,000 per day. Members are responsible for 40% percent of this \$3,000 per day, plus all charges in excess of \$3,000.		
• Outpatient surgery performed in a Participating Ambulatory Surgery Center ³ (ASC)	20%	40%
• Outpatient surgery in hospital/facility	20%	40%
• Outpatient treatment and necessary supplies	20%	40%
HOSPITALIZATION SERVICES		
Inpatient services – non-emergency		
• Inpatient physician services (Including pregnancy and maternity care) Limited to one (1) physician visit per day.	20%	40%
• Semi-private room and board, medically necessary services and supplies	\$250/admission + 20%	\$250/admission + 40% ⁴
Skilled nursing facility (SNF) services⁵		
(Combined maximum of up to 120 preauthorized days per calendar year; semi-private accommodations)		
• Freestanding SNF	20%	40% ⁴
• Hospital SNF unit	20%	40% ⁴
EMERGENCY HEALTH COVERAGE		
• Facility services (Not resulting in a direct admission)	20%	40%
• Facility services (Resulting in a direct admission)	\$250/admission + 20%	\$250/admission + 40%
• Emergency room physician visits	20%	20%
AMBULANCE SERVICES	20%	20%
PRESCRIPTION DRUG COVERAGE		
(Calendar-year Medical Deductible does not apply) ⁶		
• Calendar-year prescription drug deductible (per individual/family)	\$100 / \$300	
• Prescription drug from retail pharmacy – up to a 60 day supply	20%	20%
• Prescription drug from mail order - up to 90 day supply	20%	Not covered
PROSTHETICS/ORTHOTICS	20%	40%

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DURABLE MEDICAL EQUIPMENT		
• Home medical equipment	20%	40%
MENTAL HEALTH SERVICES (PSYCHIATRIC)⁶	Preferred Providers²	Non-Preferred Providers²
• Inpatient hospital facility services (maximum benefit \$10,000 per individual, per lifetime)	\$250/admission + 20%	\$250/admission + 40% ⁴
• Outpatient visits for mental health conditions (maximum benefit \$500 per individual, per calendar year)	50%	50%
HOME HEALTH SERVICES⁵ (Combined maximum of 60 prior authorized visits per calendar year)		
• Home health and home infusion care (See "Prescription Drug Coverage" for home self-administered injectables.)	No charge	No charge with prior authorization
OTHER		
Hospice⁵		
• Routine home care	No charge	No charge with prior authorization
• Inpatient respite Care	Not covered	Not covered
• 24 hour continuous home care and general inpatient care	No charge	No charge with prior authorization
Alternative care		
• Chiropractic services (Maximum benefit of \$125 per calendar year; per individual)	20%	40%
• Acupuncture services ⁹	20%	40%
Rehabilitative therapy services		
• Outpatient visits	20%	40%
Pregnancy and maternity care		
• Prenatal and postnatal professional (physician) services (For all necessary inpatient hospital services, see "Hospitalization Services.")	20%	40%
Family planning		
• Family planning counseling	Not covered	Not covered
• Elective abortion, tubal ligation, vasectomy ⁷	20%	40%
Covered out-of-state benefits Benefits provided through BlueCard [®] Program, for out-of-state emergency and non-emergency care, are provided at the preferred level of the local Blue Plan allowable amount when you use a Blue Cross/Blue Shield provider.	20%	40%
Diabetes care		
• Equipment, devices and non-testing supplies (For testing supplies, see "Prescription Drug Coverage.")	20%	40%
• Self-management training and education (If billed by your provider, you will also be responsible for the office visit copayment)	Not covered	Not covered

¹ Deductible and copayments marked with a (1) do not accrue to calendar-year copayment maximum, except for the percentage copay for the Outpatient Surgery in hospital/facility benefit which does accrue to the calendar-year copayment maximum. Copayments and charges for services not accruing to the member's calendar-year copayment maximum continue to be the member's responsibility after the calendar-year copayment maximum is reached. Deductible does not apply toward the calendar-year maximum. Please refer to the Evidence of Coverage, the Disclosure Form and the Plan Contract for exact terms and conditions of coverage.

² Member is responsible for copayment in addition to any charges above allowable amounts. The copayment percentage indicated is a percentage of allowable amounts. Preferred providers accept Blue Shield's allowable amount as full payment for covered services. Non-preferred providers can charge more than these amounts. When members use non-preferred providers, they must pay the applicable copayment plus any amount that exceeds Blue Shield's allowable amount. Charges above the allowable amount do not count toward the calendar-year deductible or copayment maximum.

³ Participating ambulatory surgery centers may not be available in all areas. Regardless of their availability, you can obtain outpatient surgery services from a hospital, or an ambulatory surgery center affiliated with a hospital with payment according to your health plan's hospital services benefits.

⁴ The maximum allowed charges for non-emergency hospital services received from a non-preferred hospital is \$3,000 per day. Members are responsible for 40 percent of this \$3,000 per day, plus all charges in excess of \$3,000.

⁵ Services may require prior authorization by Blue Shield. When these services are prior authorized, members pay the preferred or participating provider amount.

⁶ Mental health services are accessed through Blue Shield using Blue Shield's preferred providers or non-preferred providers.

⁷ Copayment shown is for physician's services. If the procedure is performed in a facility setting (hospital or outpatient surgery center), an additional facility copayment may apply.

⁸ Includes coverage for medically necessary prescription drugs. Member presents their Pharmacy ID card and pays 20% of the contracted rate after the Pharmacy deductible has been satisfied.

⁹ Acupuncture is a covered benefit if performed by a licensed medical physician only (not an acupuncturist). Benefits are subject to deductible and accrue to the out of pocket maximum.

¹⁰ This Plan has an additional \$1,000 benefit per individual every 24 months for Preventive Care Services. Please refer to the Evidence of Coverage, the Disclosure Form and the Plan Contract for exact terms and conditions of coverage.

Plan designs may be modified to ensure compliance with state and federal requirements