

Alhambra Unified School District
 Blue Shield Preferred Plan (100/70)
 Group 975276
 Benefit Summary

Effective October 1, 2006

DEDUCTIBLES (All providers combined)	Preferred Providers¹	Non-Preferred Providers¹
Calendar-year medical deductible (90-Day Deductible Carry-over)	\$100 per individual/\$300per family	
Calendar-year Copayment Maximum		
• Per individual/per family	None	\$600 per individual
LIFETIME MAXIMUMS	\$1,300,000	
Covered Services	Member Copayment	
Preventive Benefits (Deductible waived)		
Physician services		
• Annual Routine Physical Exam Office Visit (<i>one per calendar year, age 3 or over</i>)	No Charge	30%
• Annual Pap test & Mammography for screening & diagnostic purposes	No Charge	30%
• Laboratory, x-rays, diagnostics, immunizations and vaccinations; tuberculin tests	No Charge	30%
• Sigmoidoscopy for screening & diagnostic purposes beginning at age 50 and only once every 5 years	No Charge	30%
• Annual eye refraction in preparation for glasses	No Charge	30%
• Eye & ear screenings to age 18	No Charge	30%
• Venereal disease tests	No Charge	30%
• Blood lead level testing for all dependent children	No Charge	30%
Physician Services – Outpatient		
• Office visits/consultations	No Charge	30%
• Specialist visits and consultations	No Charge	30%
• Laboratory, x-rays and diagnostics	No Charge	30%
Physician Services – Inpatient		
• Inpatient visits and consultations	No Charge	30%
• Surgeons and assistants, anesthesiologists, pathologists, radiologists	No Charge	30%
Hospital Services – Outpatient		
• Outpatient surgery	No Charge	30%
• Renal dialysis	No Charge	30%
Hospital Services – Inpatient		
• Semi-private room and board, medically necessary services and supplies, including subacute care	No Charge	30% [#]
Well-Child Care (From birth thru and including age 16)		
• Office visits/consultations	No Charge	30%
• Laboratory, diagnostics and other services	No Charge	30%
• Immunizations; tuberculin tests	No Charge	30%
Pregnancy and Maternity Care		
• Prenatal and postnatal care	No Charge	30%
• All necessary inpatient hospital services	No Charge	30% [#]
Family Planning		
• Family planning counseling	No Charge	30%
• Elective abortion	No Charge	30%
• Tubal ligation, vasectomy	No Charge	30%
• Routine circumcision	No Charge	30%
Skilled Nursing Facility (SNF) Services		
• Semiprivate accommodations in a freestanding SNF (For hospital SNF unit, see Hospital Services-Inpatient coverage)	No Charge	30%
Home Infusion Care/Home Injectable Therapy Includes PKU Formulas and special foods (authorization required)	No Charge	30%
Home Health/Home Hospice (Prior authorization required. Maximum of \$10,000 per person per calendar year)	No Charge	30%
Facility Hospice Care (Prior authorization required. Limited to a maximum of 6 months)	No Charge	30%
Physical Medicine (\$4,000 maximum per person per calendar year combined with Chiropractic Services)		
• Office visits and related services, such as physical therapy and occupational therapy	No Charge	30%

Covered Services	Member Copayment	
Speech Therapy (\$5,000 lifetime maximum per person)	No Charge	30%
Chiropractic Services (\$4,000 maximum per person per calendar year combined with Physical Medicine)	No Charge	30%
Acupuncture Services (\$250 per person per calendar year) When rendered by an M.D. or certified acupuncturist	No Charge	30%
Mental Health Services (Psychiatric)		
• Outpatient non-severe mental health conditions# (up to 50 visits per calendar year combined with chemical dependency visits)	50% of the allowable amount	50% of the allowable amount
• Outpatient severe mental health conditions (including initial visit and psychological testing)	No Charge	30%
• Inpatient mental health conditions	No Charge	30%#
Chemical Dependency Services (Substance Abuse)		
• Inpatient medical (up to 60 days per calendar year)	20%	20%#
• Outpatient visits (up to 50 visits per calendar year combined with non-severe mental health visits)	50% of the allowable amount	50% of the allowable amount
Home Medical Equipment	No Charge	30%
Emergency Services	No Charge	No Charge
Ambulance	No Charge	No Charge
Diabetic Supplies	No Charge	30%
Christian Science		
• Practitioner (one visit per day, benefit maximum \$25.00 per day, limited to 70 visits per Calendar Year)		
• Nursing services (one visit per day, benefit maximum \$20.00 per day, limited to 70 visits per Calendar Year)		
• Sanatorium Services (maximum 70 days per Calendar Year)		

Diabetes Self-Management Education

For persons enrolled in a diabetic day care self-management education program, benefits are provided for the charges of a day care center for diabetes self-management education; and the Services of a Physician or other professional who is knowledgeable about the treatment of diabetes provided that charges for such Services do not duplicate those charged by the day care center. Diabetic day care is limited to four day care days during a consecutive 24-month period.

Hearing Aids

Payable at 80%, subject to plan deductible, up to a maximum of \$2,500 per device every 36 months, including hearing exam. Cover only one device for each ear in a 36 month period. If both devices are not purchased at the same time, the 2nd device will be suspended for review to determine that it is not for the same ear.

Covered Out-of-State Services (benefits provided through the BlueCard program) Except for certain Mental Health and Substance Abuse benefits	No Charge	30%
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Outpatient Prescription Drugs

<i>(not subject to a deductible, includes oral contraceptives)</i>	Participating Pharmacy	Non-Participating Pharmacy Prescriptions
	<i>(for up to a 90-day supply)</i>	<i>(for up to a 90-day supply)</i>
		Member pays 25% of Allowed Charge <u>plus</u> a copayment of:
Generic Drugs	\$10/prescription	\$10/prescription
Brand Drugs	\$10/prescription	\$10/prescription

1. 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 for Services which are not covered, and charges by non-Preferred Providers in excess of the amount covered by the Plan, such as Physician charges above the Allowable Amount, are the Participant's responsibility, and are not included in the maximum Calendar Year copayment responsibility calculations, and may cause a Participant's payment responsibility to exceed the maximum copayment amount.

2. The Drug Formulary includes all generic drugs and many brand drugs. If a member requests a brand name drug when a generic drug is available, the member pays the formulary brand copayment plus the difference between brand and generic drug cost.

Copayments do not apply toward the copayment maximum and continue to be charged after it is reached.