

Cabrillo Community College
SISC Blue Shield PPO Plan Comparison
Effective October 1, 2009

PLANS	BSC 90-E \$10		BSC 80-E \$10		HDHP-Plan B HSA Compatible	
Calendar Year Deductible(s)	\$300 per individual/\$600 per family		\$500 per individual/\$1,000 per family		\$2,500 per individual to \$5,000 per family	
Maximum *Co-Insurance	\$600 per individual/\$1,800 per family		\$1,000 per individual/\$3,000 per family		\$5,000 per individual to \$10,000 per family	
<i>Co-insurance is the member's responsibility to pay when the plan is paying less than 100% (i.e. plan pays 80%, member pays the other 20%)</i>	<i>Once the member's 10% co-insurance totals \$600 per individual, the plan will pay 100% of the allowable amount for the remainder of the calendar year.</i>		<i>Once the member's 20% co-insurance totals \$1,000 per individual, the plan will pay 100% of the allowable amount for the remainder of the calendar year.</i>		NOTE: This plan has an Annual Out-of-Pocket Maximum that includes the deductible, co-pays and co-insurance.	
Lifetime Maximum	\$5,000,000		\$5,000,000		\$5,000,000	
Services	Participating Providers	Non-Participating Providers	Participating Providers	Non-Participating Providers	Participating Providers	Non-Participating Providers
Office Visits	Deductible Waived \$10 co-pay	50%	Deductible Waived \$10 co-pay	50%	90%	50%
Inpatient Hospital Room, Board & Support Services (prior authorization required)	90%	50% up to \$600 per day	80%	50% up to \$600 per day	90%	50% up to \$600 per day
Ambulatory Surgery Center	90%	50% up to \$350 per day	80%	50% up to \$350 per day	90%	50% up to \$350 per day
Emergency Room (non-emergency) Facility Expenses:	90%	90% eligible expenses	80%	90% eligible expenses	\$100 co-pay	
Professional Expenses:	90%	50%	80%	50%	90%	50%
Surgeon & Anesthetist	90%	50%	80%	50%	90%	50%
Accident Care (Professional) (initial care)	90%	90%	80%	90%	90%	90%
Preventative Care	Deductible Waived, 100%	50%	Deductible Waived, 100%	50%	Deductible Waived 100%	50%
Routine Exam	Deductible Waived, 100%	Not Covered	Deductible Waived, 100%	Not Covered	Deductible Waived 100%	Not Covered
Diagnostic X-Ray & Lab	90%	50%	80%	50%	90%	50%
Physical Medicine (PT, OT, Chiro)	26 visits per year		26 visits per year		12 visits per year	
	90%	50%	80%	50%	90% up to \$25 per visit	50% up to \$25 per visit
Speech Therapy	90%	50%	80%	50%	90%	50%
Acupuncture 12 visits per year	90% up to \$50 per visit	50% up to \$25 per visit	90% up to \$50 per visit	50% up to \$25 per visit	90% up to \$30 per visit	50% up to \$30 per visit
Durable Medical Equipment	90%	90%	80%	90%	90%	90%
Hearing Aid (\$700 maximum every 24 months)	90%	90%	80%	90%	90%	90%
Hospice	90%	Not Covered unless pre authorized	80%	Not Covered unless pre authorized	90%	Not Covered unless pre authorized
Ambulance	90%	90%	80%	90%	90%	90%
Home Health Care 100 visits/yr (prior authorization required)	90%	Not Covered unless pre authorized	80%	Not Covered unless pre authorized	90%	Not Covered unless pre authorized
Psychiatric Inpatient (30 Day Max) Outpatient Visits - Severe Conditions Outpatient Visits - Non-Severe Conditions (up to 50 visits/calendar yr combined with Substance Abuse visits)	Removed from this medical plan and replaced with Pacificare Behavioral Health POS plan. Must call 800-999-7222 for prior authorization.		Removed from this medical plan and replaced with Pacificare Behavioral Health POS plan. Must call 800-999-7222 for prior authorization.		In medical coverage, subject to deductible	
Substance Abuse Inpatient For Acute Detox (30 Day Max) Outpatient Visits (up to 50 visits/calendar yr combined with Non-Severe Psychiatric visits)					10%	\$270 per day
Outpatient Prescription Drugs	Covered through Medco Health Plan 100/5-20		Covered through Medco Health Plan 100/5-20		In medical coverage, subject to deductible	
	Retail	Mail	Retail	Mail	90%	\$270 per day
	30 days	90 days	30 days	90 days	50% up to \$20	50% to \$20 per visit
Generic Drugs	\$5	\$10	\$5	\$10	Covered within the medical plan through Blue Shield	
Brand Name Drugs	\$20	\$50	\$20	\$50	Retail	Mail
					30 days	90 days
					\$7	\$14
					\$25	\$60
Brand Name Calendar Year Deductible	\$100 per individual / \$300 per family		\$100 per individual / \$300 per family		\$2,500 medical deductible must be met before co-pays apply.	

This is only a brief summary of benefits. For details of the benefits, limitations and exclusions, please refer to the Summary Plan Description.