County of San Diego IHSS
Customer ID# 228586
Member Services 1-800-464-4000

Disclosure Form Part One — Principal Benefits for High Copay HMO Scr (11/1/08—10/31/09)

The Services described below are covered only if all the following conditions are satisfied:

- The Services are Medically Necessary
- The Services are provided, prescribed, authorized, or directed by a Plan Physician and you receive the Services from Plan Providers inside our Southern California Region Service Area (your Home Region), except where specifically noted to the contrary in the *Evidence of Coverage* (*EOC*) for authorized referrals, hospice care, Emergency Care, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

Annual Out-of-Pocket Maximum for Certain Services	
For Services subject to the maximum, you will not pay any more Cost Sharing during a calendar year if the Copayments and Coinsurance you pay for those Services add up to one of the following amounts:	
For self-only enrollment (a Family Unit of one Member)	$3,000 per calendar year
For any one Member in a Family Unit of two or more Members	$3,000 per calendar year
For an entire Family Unit of two or more Members	$6,000 per calendar year
Deductible or Lifetime Maximum	None
Professional Services (Plan Provider office visits)	**You Pay**
Primary and specialty care visits (includes routine and Urgent Care appointments)	$20 per visit
Routine preventive physical exams	$20 per visit
Well-child preventive care visits (through age 23 months)	$10 per visit
Family planning visits	$20 per visit
Scheduled prenatal care visits and first postpartum visit	$10 per visit
Voluntary termination of pregnancy	$20 per procedure
Routine preventive refraction exams	$20 per visit
Routine preventive hearing tests	$20 per visit
Physical, occupational, and speech therapy visits	$20 per visit
Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	$250 per procedure
Allergy injection visits	$5 per visit
Allergy testing visits	$20 per visit
Vaccines (immunizations)	No charge
X-rays and lab tests	$10 per encounter
MRI, CT and PET	$50 per procedure
Health education:	
Individual visits	$20 per visit
Group educational programs	No charge
Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, lab tests, and drugs	$500 per day
Emergency Health Coverage	**You Pay**
Emergency Department visits	$150 per visit (does not apply if admitted directly to the hospital as an inpatient)
Ambulance Services	**You Pay**
Ambulance Services	$150 per trip
Prescription Drug Coverage	**You Pay**
Most covered outpatient items in accord with our drug formulary guidelines:	
Generic items from a Plan Pharmacy	$15 for up to a 30-day supply, $30 for a 31- to 60-day supply, or $45 for a 61- to 100-day supply
Generic refills from our mail-order service	$15 for up to a 30-day supply or $30 for a 31- to 100-day supply

continues

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Prescription Drug Coverage	You Pay
Brand-name items from a Plan Pharmacy	$35 for up to a 30-day supply, $70 for a 31- to 60-day supply, or $105 for a 61- to 100-day supply
Brand-name refills from our mail-order service	$35 for up to a 30-day supply or $70 for a 31- to 100-day supply

Durable Medical Equipment (DME)	You Pay
Covered DME for home use in accord with our DME formulary guidelines	50% Coinsurance

Mental Health Services	You Pay
Inpatient psychiatric hospitalization (up to 30 days per calendar year)	$500 per day
Outpatient visits:	
Up to a total of 20 individual and group visits per calendar year	$20 per individual visit $10 per group visit
Up to 20 additional group visits that meet the Medical Group criteria in the same calendar year	$10 per group visit

Note: Visit and day limits do not apply to serious emotional disturbances of children and severe mental illnesses as described in the *EOC*.

Chemical Dependency Services	You Pay
Inpatient detoxification	$500 per day
Outpatient individual visits	$20 per visit
Outpatient group visits	$5 per visit
Transitional residential recovery Services (up to 60 days per calendar year, not to exceed 120 days in any five-year period)	$100 per admission

Home Health Services	You Pay
Home health care (up to 100 visits per calendar year)	No charge

Other	You Pay
Skilled nursing facility care (up to 100 days per benefit period)	No charge
All covered Services related to infertility treatment	50% Coinsurance
Hospice care	No charge

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Sharing, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Sharing. For a complete explanation, please refer to the *EOC*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).