Managed Risk Medical Insurance Plan
Comparative Benefit Matrix
Effective January 1, 2011

Plan Name:	**Plan Contact Phone Number:**
Blue Shield of California HMO Post MRMIP Graduate Product	Customer Service 1-800-424-6521

Coverage Summary

Eligibility requirements	You are eligible to enroll in the Post-MRMIP Graduate Product if you meet any of the following criteria: · Apply for coverage within 63 days of the termination date of previous coverage under the MRMIP and have had continuous coverage under the MRMIP for a period of 36 consecutive months, or · Have been enrolled in a Post-MRMIP standard benefit plan and move to an area within the state that is not in the service area of the plan or insurer you previously selected and you apply for coverage within 63 days of termination of previous coverage, or · Have been enrolled in a Post-MRMIP standard benefit plan that is no longer available where you reside and apply for coverage within 63 days of the termination date of the previous coverage · Plans may decline coverage if you are eligible for Parts A and B of Medicare at the time of application and are not enrolled in Medicare solely due to end stage renal disease. Dependent Coverage-The following dependents may also be enrolled: -Subscriber's spouse -Subscriber or spouse's unmarried children -Dependent children over age 23 incapable of self-sustaining employment due to certain disabilities. (Consult the Plan's Evidence of Coverage for further information as availability of dependent coverage varies).
The full premium cost of each benefit package in the service area in which the individual and eligible dependents work and reside	Premiums charged by plans vary by region and age of subscribers. See Post-MRMIP Graduate product Rate Chart on this website.

When and under what circumstances benefits cease	Coverage may be terminated by the Plan under the following circumstances: · Loss of eligibility by Subscriber or enrolled dependents, including (1) Subscriber or Dependent(s) move out of the Plan's service area (Please contact the Plan for further details regarding the process for selection of a different Post-MRMIP Graduate Product under such circumstances) or out of California or (2) Enrolled dependents no longer meet eligibility requirements. · Termination of Plan type by Plan in which Subscriber or Dependents is enrolled (Please contact the Plan for further details regarding the process for selection of a different Post-MRMIP Graduate Product under such circumstances.) · Non-payment of subscription charges. · Fraud or material misrepresentation. (This list represents a general summary. Please consult the Plan's Evidence of Coverage for specific details regarding causes for termination by the Plan.)
The terms under which coverage may be renewed	Coverage under the Plan shall continue, except under the following circumstances: · Loss of eligibility by Subscriber or by enrolled Dependents · Non-payment of subscription charges · Fraud or material misrepresentation · Termination of plan type by Plan in which Subscriber or Dependents is enrolled (Please consult the Plan for further details regarding the process for selection of a different Post-MRMIP Graduate Product under such circumstances.) . Subscriber moves out of the service area.
Other coverage that may be available if benefits under the described benefit package cease	No other coverage is available.
The circumstances under which choice in the selection of physicians and providers is permitted	Members are encouraged to choose a primary care Plan Physician from a list of available Plan Physicians in the following specialties: internal medicine, obstetric/gynecology, family practice, and Pediatrics. Members may change their primary care Plan Physician at any time.

Coverage Summary

Lifetime and annual maximums	Lifetime Maximum: $750,000 Calendar Year Maximum: $200,000		
Deductibles	$500 Per Family per Calendar Year		
Benefit Summary (*1)		**Co-payments** Calendar Year Copayment Maximum $2,500/covered person $4,000/family	**Limitation**
Professional Services	Physician office and specialist visits	<u>Physician and Specialist Office Visits</u>: ➢ Preferred Providers: $20 ➢ Non-Preferred Providers: Not covered Preventive Care Office Visits ➢ Preferred Providers: $20 ➢ Non-Preferred Providers: Not covered	.
		<u>Internet Based Consultations:</u> ➢ Preferred Providers: Not covered ➢ Non-Preferred Providers Not covered	
		<u>Skilled Nursing Facility, or Visits to the Person's home</u>: ➢ Preferred Providers: $0 after deductible is met ➢ Non-Preferred Providers: Not covered	

		Physician Services While Hospitalized ➢ See "Hospitalization Services" ➢	
Outpatient Services	Outpatient services, including, but not limited to surgery and treatment, and diagnostic procedures.	Outpatient or Out-of-Hospital X-ray and Laboratory ➢ Preferred Providers: $0 ➢ Non-Preferred Providers: Not covered	
		Outpatient Surgery in an Ambulatory Surgery Center (ASC): ➢ Preferred Providers: $100 per surgery ➢ Non-Preferred Providers: Not covered	
		Surgery in Outpatient Department of a Hospital: ➢ Preferred Providers: $100 ➢ Non-Preferred Providers: Not covered	
		Hospital Outpatient Services: ➢ Preferred Providers: $20 per visit Non-Preferred Providers: Not covered	
		Prenatal and Postnatal Care Outpatient Rehabilitation in a Office of a physician or Office of physical, occupational, or respiratory therapist: ➢ Preferred Providers: $15 per visit ➢ Non-Preferred Providers Not covered	

		<u>Rehabilitation Services provided in a Hospital Outpatient Department</u> ➢ Preferred Providers: $20 per visit ➢ Non-Preferred Providers: Not covered	.
		<u>Family Planning Consultations:</u> ➢ Preferred Providers: $20 per visit ➢ Non-Preferred Providers: Not covered <u>Elective Abortions, Tubal Ligations :</u> ➢ Preferred Providers: $20 ➢ Non-Preferred Providers: Not covered <u>Vasectomy:</u> ➢ Preferred Providers: $20 ➢ Non-Preferred Providers: Not covered	
Hospitalization Services	Inpatient and outpatient services, including, but not limited to room board and supplies.	➢ Preferred Providers: $200 per day after deductible is paid ➢ Non-Preferred Providers: Not covered	
	Physician Inpatient Services	➢ Preferred Providers: $0 ➢ Non-Preferred Providers: Not covered	
Emergency Health Coverage	Emergency room services, including physician services, at preferred and non-preferred facilities for medically necessary emergency services.	➢ Hospital Emergency Room: $100 not resulting in admission ➢ Hospital Emergency Room: $0 if resulting in admission	

		➢ Physician Services received during ER visit: ➢ $0	
Ambulance Services	Emergency ambulance transport.	➢ $75	
Prescription Drug Benefits	Medically necessary drugs prescribed by a physician.	➢ $10 Generic Drugs; for up to 100 days ➢ $35 Brand Drugs; for up to 100 days ➢ $10 for Mail-Service Generic Drugs; for up to 100 days ➢ $35 for Mail-Service Brand Drugs; for up to 100 days ➢ $10 for Mail-Service Formulary Generic Drugs; for up to 100 days ➢ Non-Formulary drugs covered when prior authorized. Member is responsible for applicable Generic or Brand copayment ; ➢ $0 negotiated Blue Shield of California contracted rate for Home Self-Administered Injectables	➢ Drugs received from Non-Participating Pharmacies, except for emergency coverage, drugs for emergency contraception, and drugs obtained outside of California which are related to an urgently needed service and for which a Participating Pharmacy was not reasonably accessible, are not covered. ➢ Injectable Drugs for the treatment of infertility and contraceptive implants are excluded. ➢ Outpatient Prescription Drugs are limited to a quantity not to exceed a 100-day supply. ➢ Mail Service Prescription Drugs are limited to a quantity not to exceed a 100-day supply. ➢ Benefits are provided for Home Self-Administered Injectables (excluding fertility injectables) only when obtained from a pharmacy designated in a specialty network, except in the case of an emergency
Durable Medical Equipment	Durable medical equipment, including, but not limited to, oxygen, parental and enteral nutrition, colostomy supplies, corrective prosthetics and aids, and diabetic supplies.	➢ Preferred Providers: 20% of allowed charges ➢ Non-Preferred Providers: Not covered	No benefits are provided for wigs, home testing devices, environmental control equipment, self-help/educational devices or any type of speech or language assistance devices, air-conditioners, humidifiers, dehumidifiers, air purifiers, exercise equipment, or any other equipment not primarily medical in nature

Mental Health Services	Inpatient and outpatient mental health services, including, but not limited to, mental health parity services (**2) for serious mental disorders and severe emotional disturbances for children.	<u>Hospital Facility Services</u> ➢ Inpatient Participating Hospital for severe mental illness(SMI) or serious emotional disturbance(SED): $200 per day after deductible is met ➢ Outpatient Psychiatric partial hospitalization: $20 per episode(4) ➢ Outpatient psychiatric care, intensive outpatient care: $20 per visit ➢ Non Participating Hospital: Not covered <u>Partial Hospitalization Services (Inpatient Services):</u> ➢ Participating Hospital: $20 per episode(4) ➢ Non Participating Hospital: Not covered	• An episode is the date from which the patient is admitted to the Partial Hospitalizations Program to the date the patient is discharged or leaves the Partial Hospitalization Program. Any services received between these two dates would constitute the episode of care. If the patient needs to be readmitted at a later date, this would constitute another episode of care.
		<u>Inpatient Professional (Physician) Services:</u> ➢ Participating Hospital: $0 ➢ Non Participating Hospital: Not covered	
		<u>Outpatient Facility and Office Care for Severe Mental Illness or Serious Emotional Disturbances of a Child:</u> ➢ Participating Provider: $20/visit ➢ Non-Participating Provider: Not covered	

		Outpatient Facility Care and Office Visits for other than Severe Mental Illness or Serious Emotional Disturbances of a Child, Initial Visit, and Substance Abuse care: ➢ Participating Provider: $20 visit ➢ Non Participating Provider: Not covered	
Residential Treatment	Transitional residential recovery services.	Not covered	
Chemical Dependence Services	Substance abuse treatment or rehabilitation.	Outpatient Facility and Office Care ➢ Participating Provider: Not covered ➢ Non-Participating Provider: Not covered	
Home Health Services	Home health care services (***3)	➢ Participating Provider: $0 /visit ➢ Non Participating Provider: Not covered	100 visit maximum per insured per calendar year.
Custodial Care and skilled nursing facilities	Skilled Nursing care and skilled nursing facilities services.	Provided by a Hospital Skilled Nursing Facility Unit: ➢ Preferred: $0 / day after deductible is met ➢ Non-Preferred: Not covered Custodial Care: Not covered	Skill Nursing Facility Calendar-year maximum of 100 days.

(*1) For participating providers, percentage co-payments represent a percentage of actual cost, or, if the Plan pays the provider a per-member-per-month rate, an equivalent cost. Percentage co-payments for services provided by non-participating providers are a percentage of usual, customary or reasonable rates, negotiated costs, or billed charges, as determined by the Plan. Please consult the Evidence of Coverage. In a PPO plan, enrollees are also responsible for any excess amount billed by a non-participating provider.

(**2) Health Plans in California are required by law to provide certain mental health services according to the same terms and conditions as other similar medical benefits. Please contact the individual plan for further information regarding the conditions subject to mental health parity.

(***3) Hospice benefits are available through the plan. Please consult the Plan's Evidence of Coverage.