

SHASTA-TRINITY SCHOOLS INSURANCE GROUP

PLAN SUMMARY

(Effective July 1, 2009)

2009-10 PLAN COMPARISON/SUMMARY

	Anthem Blue Cross Plan C		Anthem Blue Cross Plan C-2	
	PPO	Non-PPO	PPO	Non-PPO
DEDUCTIBLE				
Per Individual Per Calendar Year	\$100	\$100	\$250	\$250
Per Family Per Calendar Year	\$300	\$300	\$750	\$750
Per Emergency Room Visit (waived if admitted)		\$35	\$35	
Per PPO Hospital Confinement	Included Above	N/A	\$500	\$500
Per Non-PPO Confinement	N/A	Included Above	N/A	Included Above
Per Non-PPO Confinement not auth.	N/A	50%	N/A	40%
LIFETIME MAXIMUMS				
Medical Care (All Services)	\$5,000,000		\$5,000,000	
OUT-OF-POCKET LIMIT <i>(Excludes Copays & Deductibles)</i>				
Per Individual per cal yr	\$1,500	\$3,000	\$3,000	\$6,000
Per Family per cal yr (Applies to all coverages)	\$3,000	\$5,000	\$6,000	\$12,000
COINSURANCE				
Physician Office Visits	80%	80%*	80%	80%*
Office Visit Copay*****	\$25	\$25	\$25	\$25
Hospital Services**	80%	70%*	80%	60%*
Ambulatory Surgical Centers	80%	70% (max. \$350/day)	80%	60% (max. \$350/day)
Preauthorization Required - waived for ER admissions**				
Emergency Room Visits	80%	80%*	80%	80%*
ER Copay*****	\$35	\$35	\$35	\$35
Non Emergency Use	70%	70%*	70%	70%*
Medical/Surgical	80%	70%*	80%	60%*
Pre-operative Testing	80%	70%*	80%	60%*
Xray & Lab (Illness/Injury Only)	80%	80%*	80%	80%*
Maternity Care	80%	70%*	80%	60%*
Home Health Care	80%	80%*	80%	80%*
Visits/calendar year	65	65	65	65
Skilled Nursing Facility Care	80%	70%	80%	60%*
Hospice Care	80%	70%*	80%	60%*
Ambulance - Ground/Air***	80%	80%	80%	80%*
Copoly*****	\$35	\$35	\$35	\$35
All other covered services	80%	70%*	80%	70%*
Prosthetic Devices	80%	70%*	80%	70%
Maximum	N/A	N/A	N/A	N/A
Durable Medical Equipment	80%	70%*	80%	60%*
Maximum	N/A	N/A	N/A	N/A
THERAPY				
Physical	80%	80%*	80%	80%*
Copoly*****	\$25	\$25	\$25	\$25
Visits/Calendar Year	40	40	40	40
Speech ****	80%	80%*	80%	80%*
Copoly*****	\$25	\$25	\$25	\$25
Visits/Calendar Year	40	40	40	40

	Anthem Blue Cross Plan C		Anthem Blue Cross Plan C-2	
	PPO	Non-PPO	PPO	Non-PPO
WELLNESS*****				
Routine Physical Exam	\$250 benefit per yr (Each family member) \$0		\$250 benefit per yr (Each family member) \$0	
Visit Copay				
Routine Diagnostic X-Ray & Lab	Included above	Included above	Included above	Included above
Routine Pap Smear	100%	100%*	100%	100%*
Routine Mammogram	100%	100%*	100%	100%*
Well Baby Care	80%	80%	80%	80%
Copay/Age of Child (through age 6)	\$25	\$25	\$25	\$25
Immunizations	100%	100%*	100%	100%*
Copay/Age of Child (through age 18)	\$25	\$25	\$25	\$25
MENTAL HEALTH CARE				
Inpatient Hospital Care**	80%	80%	80%	80%
Maximum	30 days	30 days	30 days	30 days
Outpatient Care -				
1st-10th Visit	100%	100%*	100%	100%*
11th - 40th Visit	55%	55%	0%	0%
41st-50th Visit	0%	0%	0%	0%
CHEMICAL DEPENDENCY CARE				
Inpatient Hospital Care**	80%	80%*	80%	80%
Maximum	Detox Only		Detox Only	
Outpatient Care -				
1st-10th Visit	100%*	100%*	No benefit	No benefit
11th - 40th Visit	55%*	55%*	No benefit	No benefit
41st-50th Visit	0%	0%	No benefit	No benefit
CHIROPRACTIC CARE				
Benefit	80%	No benefit	No benefit	No benefit
Copay*****	\$25			
Maximum/calendar year	40			
ACUPUNCTURE				
Benefit	Combined w/Chiro	No benefit	No benefit	No benefit
Maximum/calendar year				
PRESCRIPTION DRUG				
Mandatory Generic/Closed Formulary				
RETAIL PHARMACY				
Generic Copay	\$20	\$20 + 50%	\$20	\$20 + 50%
Brand Copay (Formulary)	\$30	\$30 + 50%	\$30	\$30 + 50%
Brand Copay (Non-Formulary)	\$40	\$40 + 50%	\$40	\$40 + 50%
Maximum Supply	30 days		30 days	
MAIL ORDER SERVICE (Mandatory)				
Generic Copay	\$40	N/A	\$40	N/A
Brand Copay (Formulary)	\$60		\$60	
Brand Copay (Non-Formulary)	\$80		\$80	
Maximum Supply	90 days	N/A	90 days	N/A

This summary is intended for comparison purposes only. The certificate should be viewed for a detailed explanation of the plan coverage.

* Subject to UCR. Strongly recommend utilization of PPO network except where indicated.

** Pre-certification required. 20% penalty if not preauthorized.

*** Medically Necessary Only

**** No benefits except following surgery, injury or non-congenital organic disease.

*****Deductible waived where applicable

*****Deductible waived if admitted to facility immediately following ER treatment.