

SISC

Custom SaveNet Per Admit 25-500

Benefit Summary (For groups of 300 and above)  
(Uniform Health Plan Benefits and Coverage Matrix)

**THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.**

**Blue Shield of California**

Highlights: A description of the prescription drug coverage is provided separately

This plan has a special network including a limited number of Physicians, Independent Practice Associations (IPAs) and Medical Groups and a limited Service Area which includes only certain counties and cities as described in the Evidence of Coverage and Access+ HMO Comparison. You must live and/or work in this limited Service Area in order to enroll in this Plan

Effective October 1, 2013

<b>Calendar Year Medical Deductible</b>	None
<b>Calendar Year Copayment Maximum<sup>1</sup></b> (For many covered services)	\$2,000 per individual / \$4,000 per family
<b>LIFETIME BENEFIT MAXIMUM</b>	None
<b>Covered Services</b>	<b>Member Copayment</b>
<b>PROFESSIONAL SERVICES</b>	
<b>Professional (Physician) Benefits</b>	
• Physician and specialist office visits (Note: A woman may self-refer to an OB/GYN or family practice physician in her Personal Physician's medical group or IPA for OB/GYN services)	\$25 per visit
• Outpatient X-ray, pathology and laboratory	No Charge
<b>Allergy Testing and Treatment Benefits</b>	
• Office visits (includes visits for allergy serum injections)	\$25 per visit
<b>Access+ Specialist<sup>SM</sup> Benefits<sup>1,2</sup></b>	
• Office visit, Examination or Other Consultation (Self-referred office visits and consultations only)	\$30 per visit
<b>Preventive Health Benefits</b>	
• Preventive Health Services (As required by applicable federal and California law.)	No Charge
<b>OUTPATIENT SERVICES</b>	
<b>Hospital Benefits (Facility Services)</b>	
• Outpatient surgery performed at an Ambulatory Surgery Center <sup>3</sup>	\$150 per surgery
• Outpatient surgery in a hospital	\$300 per surgery
• Outpatient Services for treatment of illness or injury and necessary supplies (Except as described under "Rehabilitation Benefits" and "Speech Therapy Benefits")	No Charge
<b>HOSPITALIZATION SERVICES</b>	
<b>Hospital Benefits (Facility Services)</b>	
• Inpatient Physician Services	No Charge
• Inpatient Non-emergency Facility Services (Semi-private room and board, and medically-necessary Services and supplies, including Subacute Care)	\$500 per admission
• Inpatient Medically Necessary skilled nursing Services including Subacute Care <sup>4,5</sup>	\$100 per day
<b>EMERGENCY HEALTH COVERAGE</b>	
• Emergency room Services not resulting in admission (Copayment does not apply if the member is directly admitted to the hospital for inpatient services)	\$100 per visit
• Emergency room Physician Services	No Charge
<b>AMBULANCE SERVICES</b>	
• Emergency or authorized transport	\$100
<b>PRESCRIPTION DRUG COVERAGE</b>	
<b>Outpatient Prescription Drug</b>	Carved out to Express Scripts 1-800-987-5241
<b>PROSTHETICS/ORTHOTICS</b>	
• Prosthetic equipment and devices (Separate office visit copay may apply)	No Charge
• Orthotic equipment and devices (Separate office visit copay may apply)	No Charge

<b>DURABLE MEDICAL EQUIPMENT</b>	
• Breast pump	No Charge
• Other Durable Medical Equipment (member share is based upon allowed charges)	20%
<b>MENTAL HEALTH SERVICES (PSYCHIATRIC)<sup>6</sup></b>	
• Inpatient Hospital Services	\$500 per admission
• Outpatient Mental Health Services	\$25 per visit
<b>CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)<sup>7</sup></b>	
<b>Please see footnote 10</b>	
• Chemical dependency and substance abuse services	Not Covered
<b>HOME HEALTH SERVICES</b>	
• Home health care agency Services (up to 100 visits per Calendar Year)	\$25 per visit
• Medical supplies and laboratory Services	No Charge
<b>OTHER</b>	
<b>Hospice Program Benefits</b>	
• Routine home care	No Charge
• Inpatient Respite Care	No Charge
• 24-hour Continuous Home Care	\$250 per day
• General Inpatient care	\$250 per day
<b>Hearing Aid</b>	
• Audiological evaluations	\$25 per day
• Hearing Aid Instrument and ancillary equipment (every 24 months for the hearing aid and ancillary equipment)	50%
<b>Pregnancy and Maternity Care Benefits</b>	
• Prenatal and postnatal Physician office visits (For inpatient hospital services, see "Hospitalization Services.")	No Charge
<b>Family Planning and Infertility Benefits</b>	
• Counseling and consulting <sup>8</sup>	No Charge
• Infertility Services (member share is based upon allowed charges) (Diagnosis and treatment of cause of infertility. Excludes in vitro fertilization, injectables for infertility, artificial insemination and GIFT).	50%
• Tubal ligation	No Charge
• Elective abortion <sup>9</sup>	\$100 per surgery
• Vasectomy <sup>9</sup>	\$75 per surgery
<b>Rehabilitation Benefits (Physical, Occupational and Respiratory Therapy)</b>	
• Office location (Copayment applies to all places of services, including professional and facility settings)	\$25 per visit
<b>Speech Therapy Benefits</b>	
• Office Visit - Services by licensed speech therapists (Copayment applies to all places of services, including professional and facility settings)	\$25 per visit
<b>Diabetes Care Benefits</b>	
• Devices, equipment, and non-testing supplies (member share is based upon allowed charges)	20%
• Diabetes self-management training	\$25 per visit
<b>Urgent Care Benefits (BlueCard<sup>®</sup> Program)</b>	
• Urgent Services outside your Personal Physician Service Area	\$50 per visit
<b>Optional Benefits<sup>1</sup></b>	Optional dental, vision, infertility, substance abuse, chiropractic or chiropractic and acupuncture benefits are available. If your employer purchased any of these benefits, a description of the benefit is provided separately.

1 Copayments marked with this footnote do not accrue to the calendar-year copayment maximum. Copayments and charges for services not accruing to the member's calendar-year copayment maximum continue to be the member's responsibility after the calendar-year copayment maximum is reached. Please refer to the Evidence of Coverage and the Plan Contract for exact terms and conditions of coverage.

2 To use this option, members must select a personal physician who is affiliated with a medical group or IPA that is an Access+ provider group, which offers the Access+ Specialist feature. Members should then select a specialist within that medical group or IPA. Access+ Specialist visits for mental health services must be provided by a MHS network participating provider.

3 Participating ambulatory surgery centers may not be available in all areas. Regardless of their availability, you can obtain outpatient surgery services from a hospital or an ambulatory surgery center affiliated with a hospital, with payment according to your health plan's hospital services benefits.

4 For Plans with a facility deductible amount, services with a day or visit limit accrue to the calendar-year day or visit limit maximum regardless of whether the plan deductible has been met.

5 Skilled nursing services are limited to 100 preauthorized days during a calendar year except when received through a hospice program provided by a participating hospice agency. This 100 preauthorized day maximum on skilled nursing services is a combined maximum between SNF in a hospital unit and skilled nursing facilities.

6 Mental health services are accessed through Blue Shield's Mental Health Service Administrator (MHSA) using Blue Shield's MHS network participating providers. For a listing of severe mental illnesses, including serious emotional disturbances of a child, and other benefit details, please refer to the Evidence of Coverage and Plan Contract.

7 Inpatient services for acute detoxification are covered under the medical benefit; see hospitalization services for benefit details. Services for medical acute detoxification are accessed through Blue Shield using Blue Shield HMO providers.

8 Includes insertion of IUD as well as injectable contraceptives for women.

- 9 Physician services copayment in the office or outpatient hospital facility only. If procedure is performed in a hospital facility setting, additional hospital services copayment may apply.
- 10 **Optional substance abuse treatment benefits are available. If your employer purchased these benefits, a description of the benefit is attached hereto as "Additional Substance Abuse Treatment Benefits."**

Plan designs may be modified to ensure compliance with state and federal requirements.

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