SISC
Blue Shield of California 80% Plan G $10 Copayment
Benefit Summary
(Uniform Health Plan Benefits and Coverage Matrix)

Blue Shield of California

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

Effective: October 1, 2013

	Preferred Providers[1]	Non-Preferred Providers[1]
Calendar Year Medical Deductible (All providers combined)[2]	$500 per individual / $1,000 per family	
Calendar Year Copayment Maximum[2] (Copayments for Preferred Providers accrue to both Preferred and Non-Preferred Provider Calendar-year Copayment Maximum amounts.)	$1,000 per individual / $3,000 per family	
LIFETIME BENEFIT MAXIMUM	None	

Covered Services	Member Copayment	
PROFESSIONAL SERVICES	**Preferred Providers[1]**	**Non-Preferred Providers[1]**
Professional (Physician) Benefits		
• Physician and specialist office visits	$10 per visit [2] (Not subject to the Calendar-Year Deductible)	50% [2]
• CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine (prior authorization is required)[3]	20%	50% [2]
• Other outpatient X-ray, pathology and laboratory (Diagnostic testing by providers other than outpatient laboratory, pathology, and imaging departments of hospitals/facilities)[3]	20%	50% [2]
Allergy Testing and Treatment Benefits		
• Office visits (includes visits for allergy serum injections)	20%	50% [2]
Preventive Health Benefits		
• Preventive Health Services (As required by applicable federal law.)	No Charge (Not subject to the Calendar-Year Deductible)	Not Covered
OUTPATIENT SERVICES		
Hospital Benefits (Facility Services)		
• Outpatient surgery performed at an Ambulatory Surgery Center[4]	20%	No Charge [5]
• Outpatient surgery in a hospital	20%	No Charge [5]
• Outpatient Services for treatment of illness or injury and necessary supplies (Except as described under "Rehabilitation Benefits")	20%	50% [2]
• CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine performed in a hospital (prior authorization is required)[3]	20%	50% [5, 2]
• Other outpatient X-ray, pathology and laboratory performed in a hospital[3]	20%	50% [5, 2]
• Bariatric Surgery (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only)[6]	20%	No Charge [5]
HOSPITALIZATION SERVICES		
Hospital Benefits (Facility Services)		
• Inpatient Physician Services	20%	50% [2, 15]
• Inpatient Non-emergency Facility Services (Semi-private room and board, and medically-necessary Services and supplies, including Subacute Care)	20%	No Charge [7]
• Bariatric Surgery (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only)[6]	20%	No Charge [7]
Skilled Nursing Facility Benefits[8] (Combined maximum of up to 100 prior authorized days per Calendar Year; semi-private accommodations)		
• Services by a free-standing Skilled Nursing Facility	20%	20% [9]
• Skilled Nursing Unit of a Hospital	20%	No Charge [7]

EMERGENCY HEALTH COVERAGE		
• 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 + 20%	$100 per visit + 20%
• Emergency room Services resulting in admission (when the member is admitted directly from the ER)	20%	20%
• Emergency room Physician Services	20%	20% [15]
AMBULANCE SERVICES		
• Emergency or authorized transport	20%	20%
PRESCRIPTION DRUG COVERAGE		
Outpatient Prescription Drug Benefits	**Administered by Express Scripts (800) 987-5241**	
PROSTHETICS/ORTHOTICS		
• Prosthetic equipment and devices (Separate office visit copay may apply)	20%	50% [2]
• Orthotic equipment and devices (Separate office visit copay may apply)	20%	50% [2]
DURABLE MEDICAL EQUIPMENT		
• Breast Pump	No Charge (Not subject to the Calendar-Year Deductible)	Not Covered
• Durable Medical Equipment	20%	50% [2]
MENTAL HEALTH SERVICES (PSYCHIATRIC)[10]		
• Inpatient Hospital Services	20%	No Charge [7]
• Outpatient Mental Health Services	$10 per visit [2] (Not subject to the Calendar-Year Deductible)	50% [2]
CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)[10, 11]		
• Inpatient Hospital Services	20%	No Charge [7]
• Chemical dependency and substance abuse services	$10 per visit [2] (Not subject to the Calendar-Year Deductible)	50% [2]
HOME HEALTH SERVICES[12]		
• Home health care agency Services (up to 100 prior authorized visits per Calendar Year)[8]	20%	Not Covered [12]
• Home infusion/home intravenous injectable therapy and infusion nursing visits provided by a Home Infusion Agency	20%	Not Covered [12]
OTHER		
Hospice Program Benefits		
• Routine home care	20%	Not Covered [12]
• Inpatient Respite Care	20%	Not Covered [12]
• 24-hour Continuous Home Care	20%	Not Covered [12]
• General Inpatient care	20%	Not Covered [12]
Chiropractic Benefits[8]		
• Chiropractic Services - (provided by a chiropractor) (up to 20 visits per Calendar Year)	20%	50% [2]
Acupuncture Benefits[8]		
• Acupuncture - (up to 12 visits per Calendar Year)	20% (Maximum plan payment of $50 per visit)	50% (Maximum plan payment of $25 per visit)
Rehabilitation Benefits (Physical, Occupational and Respiratory Therapy)		
• Office location	20%	50% [2]
Speech Therapy Benefits		
• Office Visit	20%	50% [2]
Pregnancy and Maternity Care Benefits		
• Prenatal and postnatal Physician office visits (For inpatient hospital services, see "Hospitalization Services.")	$10 per visit [2] (Not subject to the Calendar-Year Deductible)	50% [2]
Family Planning Benefits		
• Counseling and consulting[13]	No Charge (Not subject to the Calendar-Year Deductible)	Not Covered
• Elective abortion[14]	20%	Not Covered
• Tubal ligation	No Charge (Not subject to the Calendar-Year Deductible)	Not Covered

• Vasectomy[14]	20%	Not Covered
Diabetes Care Benefits		
• Devices, equipment, and non-testing supplies (for testing supplies see Outpatient Prescription Drug Benefits.)	20%	50% [2]
• Diabetes self-management training (If billed by your provider, you will also be responsible for the office visit copayment)	$10 per visit [2] (Not subject to the Calendar-Year Deductible)	50% [2]
Hearing Aid		
• Audiological evaluations	$10 per visit [2] (Not subject to the Calendar-Year Deductible)	50%[2]
• Hearing Aid (Maximum combined benefit of $700 per person every 24 months for hearing aid and ancillary equipment)	20%	20%
Care Outside of Plan Service Area (Benefits provided through the BlueCard® Program for out-of-state emergency and non-emergency care are provided at the preferred level of the local Blue Plan allowable amount when you use a Blue Cross/Blue Shield provider)		
• Within US: BlueCard Program	See Applicable Benefit	See Applicable Benefit
• Outside of US: BlueCard Worldwide	See Applicable Benefit	See Applicable Benefit

1 Member is responsible for copayment in addition to any charges above allowable amounts. The copayment percentage indicated is a percentage of allowable amounts. Preferred providers accept Blue Shield's allowable amount as full payment for covered services. Non-preferred providers can charge more than these amounts. When members use non-preferred providers, they must pay the applicable copayment plus any amount that exceeds Blue Shield's allowable amount. Charges above the allowable amount do not count toward the calendar-year deductible or copayment maximum.

2 Deductible and copayments marked with this footnote do not accrue to 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. Deductible does not apply toward the calendar-year maximum. Please refer to the Plan Contract for exact terms and conditions of coverage.

3 Participating non Hospital based ("freestanding") outpatient X-ray, pathology and laboratory facilities centers may not be available in all areas. Regardless of their availability, you can obtain outpatient X-ray, pathology and laboratory 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 Participating ambulatory surgery facilities 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.

5 The maximum plan payment for non-emergency surgery and services performed in a non-participating Ambulatory Surgery Center or outpatient unit of a non-preferred hospital is $350 per day. Members are responsible for all charges in excess of $350.

6 Bariatric surgery is covered when pre-authorized by the Plan. However, for members residing in Imperial, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Barbara and Ventura Counties ("Designated Counties"), bariatric surgery services are covered only when performed at designated contracting bariatric surgery facilities and by designated contracting surgeons; coverage is not available for bariatric services from any other preferred provider and there is no coverage for bariatric services from non-preferred providers. In addition, if prior authorized by the Plan, a member in a Designated County who is required to travel more than 50 miles to a designated bariatric surgery facility will be eligible for limited reimbursement for specified travel expenses for the member and one companion. Refer to the Plan Contract for further benefit details.

7 The maximum plan payment for non-emergency hospital services received from a non-preferred hospital is $600 per day. Members are responsible for all charges in excess of $600.

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

9 Services may require prior authorization by the Plan. When services are prior authorized, members pay the preferred or participating provider amount.

10 Mental health services are accessed through Blue Shield's participating and non-participating providers.

11 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's preferred providers or non-preferred providers.

12 Out of network home health care, home infusion and hospice services are not covered unless pre-authorized. When these services are pre-authorized, the member pays the Preferred Provider copayment.

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

14 Copayment shown is for physician's services. If the procedure is performed in a facility setting (hospital or outpatient surgery center), an additional facility copayment may apply. Services from non-participating providers and non-preferred facilities are not covered under this benefit.

15 When these services are rendered by a non-preferred Radiologist, Anesthesiologist, Pathologist and Emergency Room Physicians in a preferred facility, the member pays the Preferred Provider copayment.

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

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