

SISC
 Blue Shield of California 80%
 Plan G - \$30 Copayment
 (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 PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Blue Shield of California

Effective October 1, 2011

	Preferred Providers ¹	Non-Preferred Providers ¹
Calendar year Medical Deductible² (All providers combined) (4 th quarter carryover applies)	\$500 per individual	\$1,000 per family
Calendar year Copayment Maximum² (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	
	Preferred Providers ¹	Non-Preferred Providers ¹
PROFESSIONAL SERVICES		
Professional (Physician) Benefits		
• Physician and specialist office visits	\$30 per visit ^{2, 5}	50% ²
• Diagnostic testing	20%	50% ²
• 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		
• Annual routine physical examination, vision and hearing screening and immunizations	No charge ⁵	Not covered
• Routine laboratory services, including annual mammography, Papanicolaou test, or cervical cancer and human papillomavirus (HPV) screening (One per calendar year)	No charge ⁵	50% ²
• Well baby care (Includes: eye/ear screenings, immunizations, vaccinations)	No charge ⁵	50% ²
• Well baby laboratory	No charge ⁵	50% ²
OUTPATIENT SERVICES		
Hospital Benefits (Facility Services)		
• Outpatient surgery performed at an Ambulatory Surgery Center ³	20%	No charge ¹² (up to \$350 per day maximum payment)
• Outpatient surgery in a hospital	20%	No charge ¹² (up to \$350 per day maximum payment)
• Outpatient Services for treatment of illness or injury and necessary supplies (Except as described under "Rehabilitation benefits")	20%	50% ²
• Outpatient X-ray, pathology and laboratory performed in a hospital ³	20%	50% ^{2, 12} (up to \$350 per day maximum payment)
• Outpatient diagnostic testing performed in a hospital ³	20%	50% ^{2, 12} (up to \$350 per day maximum payment)
• Bariatric Surgery (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity) ⁴	20%	No charge ¹² (up to \$350 per day maximum payment)
HOSPITALIZATION SERVICES		
Hospital Benefits (Facility Services)		
• Inpatient Physician Services	20%	50% ^{2, 13}
• Inpatient Non-emergency Facility Services (Semi-private room and board, medically necessary services and supplies)	20%	No charge ¹² (up to \$600 per day maximum payment)
• Bariatric Surgery (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity) ⁴	20%	No charge ¹² (up to \$600 per day maximum payment)

An Independent member of the Blue Shield Association

Skilled Nursing Facility Benefits (Combined maximum of up to 100 preauthorized days per calendar year; semi-private accommodations)

• Services by a free-standing Skilled Nursing Facility	20%	20% ⁶
• Skilled Nursing Unit of a Hospital	20%	No charge ¹² (up to \$600 per day maximum payment)

EMERGENCY HEALTH COVERAGE

• Emergency room Services not resulting in admission	\$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% ¹³

AMBULANCE SERVICES

• Emergency or authorized transport	20%	20%
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PRESCRIPTION DRUG COVERAGE**Outpatient Prescription Drug Benefits** **Administered by Medco****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

• Durable Medical Equipment	20%	50% ²
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MENTAL HEALTH SERVICES (PSYCHIATRIC)⁷

• Inpatient Hospital Services	20%	No charge ¹² (up to \$600 per day maximum payment)
• Outpatient Mental Health Services	\$30 per visit ^{2, 5}	50% ²

CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)⁸

• Inpatient Hospital Services	20%	No charge ¹² (up to \$600 per day maximum payment)
• Outpatient Chemical Dependency and Substance Abuse Services	\$30 per visit ^{2, 5}	50% ²

HOME HEALTH SERVICES⁹

• Home health care agency Services (Maximum of 100 prior authorized visits per Calendar Year)	20%	Not covered ⁹
• Home infusion/home intravenous injectable therapy and infusion nursing visits provided by a Home Infusion Agency	20%	Not covered ⁹

OTHER**Hospice Program Benefits⁹**

• Routine home care	20%	Not covered ⁹
• Inpatient Respite Care	20%	Not covered ⁹
• 24-hour Continuous Home Care	20%	Not covered ⁹
• General Inpatient care	20%	Not covered ⁹

Chiropractic Benefits¹⁰

• Chiropractic Services - provided by a chiropractor (Up to 20 visits per calendar year)	20%	50% ²
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Acupuncture Benefits¹⁰

• Acupuncture (Up to 12 visits per calendar year)	20% (Maximum plan payment of \$50 per visit)	20% ² (Maximum plan payment of \$50 per visit)
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Rehabilitation Benefits (Physical, Occupational and Respiratory Therapy)

• Office location	20%	50% ²
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Speech Therapy Benefits

• Office location	20%	50% ²
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Pregnancy and Maternity Care Benefits

• Prenatal and Postnatal Physician Office Visits (For inpatient hospital services, see "Hospitalization Services.")	\$30 per visit ^{2, 5}	50% ²
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Family Planning Benefits

• Counseling and consulting	20%	Not covered
• Elective abortion ¹¹	20%	Not covered
• Tubal ligation ¹¹	20%	Not covered
• Vasectomy ¹¹	20%	Not covered

Diabetes Care Benefits

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|---|--------------------------------|------------------|
| • Devices, equipment, and non-testing supplies | 20% | 50% ² |
| • Diabetes self-management training (If billed by your provider, you will also be responsible for the office visit copayment) | \$30 per visit ^{2, 5} | 50% ² |

Hearing Aid

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| • Hearing Aid (Maximum combined benefit of \$700 per person every 24 months for hearing aid and ancillary equipment) | 20% | 20% |
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Care Outside of Plan Service Area Benefits provided through 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/BlueShield provider.

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|-------------------------------------|------------------------|------------------------|
| • 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 a (2) 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 ambulatory surgery and 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 surgery services or 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 Bariatric surgery is covered when pre-authorized by Blue Shield. 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 Blue Shield of California, 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.
- 5 These services are not subject to the Calendar-Year Deductible.
- 6 Services may require prior authorization by Blue Shield. When these services are prior authorized, members pay the preferred or participating provider amount.
- 7 Mental health services are accessed using Blue Shield's participating and non-participating providers.
- 8 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.
- 9 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.
- 10 All outpatient acupuncture and chiropractic visits accrue to the calendar-year visit maximum regardless of whether the plan deductible has been met.
- 11 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.
- 12 Members are responsible for all charges in excess of the day maximum payment.
- 13 Services by non preferred hospital based physician provided in a preferred facility will be reimbursed at 80% of Blue Shield's allowable amount. Please refer to the Plan Contract for exact terms and conditions of coverage.

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

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