

SISC Blue Shield of California
High Deductible Health Plan

Blue Shield of California

Benefit Summary

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, DISCLOSURE FORM AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Plan B – Deductible \$2,500 individual coverage deductible or \$5,000 family coverage deductible

Effective October 1, 2008

DEDUCTIBLES	Preferred Providers¹	Non-Preferred Providers¹
Calendar-year deductible (All providers combined. Last quarter carryover is NOT provided. For individual on family coverage plan, enrollee can receive benefits for covered services once individual deductible is met.)	\$2,500 per individual/\$5,000 per family	
Calendar-year out-of-pocket maximum¹ (Includes the plan deductible)	\$5,000 per individual/\$10,000 per family	
LIFETIME MAXIMUM		\$5,000,000
Covered Services	Member Copayment	
	Preferred Providers¹	Non-Preferred Providers¹
PROFESSIONAL SERVICES,		
Physician services		
• Physician and specialist office visits	10%	50%
• Laboratory and X-rays	10%	50%
• Allergy testing or treatment	10%	50%
• Diagnostic testing (requires prior authorization)	10%	50%
• Surgeon and anesthesiologist	10%	50%
Preventive care (age 7 and older)		
• Annual routine physical exam	\$25/visit ²	Not covered
• Laboratory, including mammogram and Pap test screening or other FDA-approved cervical cancer screening tests (one per calendar year)	10% ²	50%
Well-baby / Well-child care (up to age 7)		
• Office visits and consultations (includes eye/ear screenings, immunizations, vaccinations)	\$25/visit ²	50%
• Laboratory	10% ²	50%
OUTPATIENT SERVICES		
The maximum plan payment for non-emergency surgery and services performed in a non-participating Ambulatory Surgery Center is \$350 per day. Members are responsible for their percent copayment, plus all charges in excess of \$350.		
• Outpatient surgery performed in a Participating Ambulatory Surgery Center ³ (ASC)	10%	50%
• Outpatient surgery in hospital/facility	10%	10%
• Outpatient treatment and necessary supplies	10%	10%
HOSPITALIZATION SERVICES		
Inpatient services – non-emergency		
• Inpatient physician services (including pregnancy and maternity care)	10%	50%
• Semi-private room and board, medically necessary services and supplies	10%	50% ⁴
Skilled nursing facility (SNF) services⁵ (Combined maximum of up to 100 preauthorized days per confined period)		
• Freestanding SNF	10%	10%
• Hospital SNF unit	10%	10%
EMERGENCY HEALTH COVERAGE		
• ER facility services (Members must meet an additional \$100 copayment per emergency room visit before benefits apply. This copayment is waived if the member is directly admitted to the hospital for inpatient services)	10%	10%
• Inpatient facility services (when the member is admitted directly from the ER)	10%	10%
• Emergency room physician visits	10%	10%
AMBULANCE SERVICES	10%	10%

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PRESCRIPTION DRUG COVERAGE⁷ (Subject to deductible; includes oral contraceptives and diaphragms)

Retail prescriptions (For up to a 30-day supply)	Participating Pharmacy	Non-Participating Pharmacy
• Generic drugs	\$7/prescription	\$7/prescription
• Brand-name drugs	\$25/prescription	\$25/prescription
Mail service prescriptions (For up to a 90-day supply)		
• Generic drugs	\$14/prescription	Not covered
• Brand-name drugs	\$60/prescription	Not covered
• Home self-administered injectable medications (May require prior authorization from Blue Shield Pharmacy Services; not covered through mail service benefit; available at Specialty Pharmacy provider only; up to 30 day supply)	\$25	Not covered
PROSTHETICS/ORTHOTICS (Equipment and devices only) ⁶	10%	50%
DURABLE MEDICAL EQUIPMENT⁶	10%	50%
MENTAL HEALTH SERVICES (PSYCHIATRIC) & CHEMICAL DEPENDENCY SERVICES⁸		
• Inpatient	10%	Maximum plan payment \$270 per day
• Outpatient visits (plan payment up to \$20/visit for preferred an non-preferred providers)	50%	50%
HOME HEALTH SERVICES⁹ (Up to 100 combined prior authorized visit maximum per calendar year)		
• Home health and home infusion care	10%	Not covered ⁹
OTHER		
Hospice⁹ (\$10,000 maximum per member per lifetime)		
• Routine home care and inpatient respite care	10%	Not covered ⁹
• 24 hour continuous home care and general inpatient care	10%	Not covered ⁹
Pregnancy and maternity care		
• Prenatal and postnatal professional (physician) services (For all necessary inpatient hospital services, see "Hospitalization Services.")	10%	50%
Family planning		
• Family planning counseling	10%	50%
• Tubal ligation, elective abortion, vasectomy ¹⁰	10%	50%
Rehabilitative therapy services		
• Outpatient visits (medically necessary, up to 12 visits per calendar year combined with chiropractic services; plan payment up to \$25/visit for preferred and non-preferred providers)	10%	50%
Acupuncture services (Up to 12 visits per calendar-year and plan payment up to \$30/visit for preferred and non-preferred providers) ³	10%	50%
Chiropractic services (Up to 12 visits per calendar year combined with rehabilitative therapy services; plan payment up to \$25/visit for preferred and non-preferred providers) ⁸	10%	50%
Covered out-of-state services 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/Blue Shield provider.	See Applicable Benefit Line	See Applicable Benefit Line
Diabetes care		
• Equipment, devices and supplies	10%	50%
• Self-management training and education (If billed by your provider, you will also be responsible for the office visit copayment)	\$25/visit	50%
Hearing Aid		
• Hearing aid and examination (maximum combined benefit payment of \$1,000 per person every 36 months for hearing aid and ancillary equipment)	10%	10%

1 Member is responsible for copayment in addition to any charges above allowable amounts. The copayment percentage indicated in 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 The preventive care and well-baby care office visit are not subject to the plan deductible. Other covered services received during or in connection with the office visit are subject to the plan deductible and the applicable copayment percentage.

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 The maximum plan payment for non-emergency hospital services received from a non-preferred hospital is \$580

per day. Members are responsible for their percent copayment, plus all charges in excess of \$580.

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

6 Requires prior authorization for benefits over \$500.

7 For the Outpatient Drugs benefit, covered drugs obtained from Non-Participating Pharmacies will be subject to and accrue to the deductible and the copay maximum for Preferred Providers.

8 All mental health, substance abuse, acupuncture and chiropractic visits accrue to the calendar-year visit maximum regardless of whether the plan deductible has been met.

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 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.

