

SISC

Blue Shield of California 90% - Plan E  
Benefit Summary

(Uniform Health Plan Benefits and Coverage Matrix)

Blue Shield of California

Plan E – Deductible \$300 / \$600 – Copayment Maximum \$600 / \$1800

Effective October 1, 2007

**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.**

DEDUCTIBLES <sup>1</sup> (All providers combined)	Preferred Providers <sup>2</sup>	Non-Preferred Providers <sup>2</sup>
	Calendar-year medical deductible	\$300 per individual / \$600 per family
Calendar-year Copayment Maximum <sup>1</sup>	\$600 per individual / \$1,800 per family	
LIFETIME MAXIMUMS	\$5,000,000	
Covered Services	Member Copayment	
<b>PROFESSIONAL SERVICES</b>	Preferred Providers <sup>2</sup>	Non-Preferred Providers <sup>2</sup>
<b>Physician services</b>		
• Physician and specialist office visits	\$10/visit <sup>1</sup> (Deductible Waived)	50% <sup>1</sup>
• Laboratory and X-rays	10%	50% <sup>1</sup>
• Allergy testing or treatment	10%	50% <sup>1</sup>
• Diagnostic testing (requires prior authorization)	10%	50% <sup>1</sup>
• Surgeon and anesthesiologist	10%	50% <sup>1</sup>
<b>Preventive care</b>		
• Annual routine physical exam and immunizations for dependent children (age 0 – 25)	10% (Deductible Waived)	50% <sup>1</sup>
• Annual routine physical exam for employee and spouse	10% (Deductible Waived)	Not covered
• Laboratory, including mammogram and Pap test screening or other FDA-approved cervical cancer screening tests (One per calendar year)	10% (Deductible Waived)	50% <sup>1</sup>
<b>OUTPATIENT SERVICES</b>		
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 all charges in excess of \$350.		
• Outpatient surgery performed in a Participating Ambulatory Surgery Center <sup>3</sup> (ASC)	10%	50% <sup>1</sup> , maximum plan payment of \$350 per day
• Outpatient surgery in hospital/facility	10%	10% <sup>1, 8</sup>
• Outpatient treatment and necessary supplies	10%	10% <sup>1, 8</sup>
<b>HOSPITALIZATION SERVICES</b>		
<b>Inpatient services – non-emergency</b>		
• Inpatient physician services (Including pregnancy and maternity care)	10%	50% <sup>1</sup>
• Semi-private room and board, medically necessary services and supplies	10%	50% <sup>1, 4</sup> ; maximum plan payment of \$580 per day
<b>Skilled nursing facility (SNF) services<sup>6</sup></b> (Combined maximum of up to 100 days per confined period)	10%	10%
<b>EMERGENCY HEALTH COVERAGE</b>		
• Facility services	10%	10%
• Emergency room physician services	10%	10%
<b>AMBULANCE SERVICES</b>	10%	10%
<b>PRESCRIPTION DRUG COVERAGE</b>	Administered by Medco Health	
<b>DURABLE MEDICAL EQUIPMENT<sup>5</sup></b>	10%	10%
<b>MENTAL HEALTH SERVICES (PSYCHIATRIC) &amp; CHEMICAL DEPENDENCY SERVICES</b>	All benefits are covered by PacifiCare Behavioral Health (including acute detoxification). Please contact 1-800-999-9585.	
<b>HOME HEALTH SERVICES<sup>6</sup></b> (Combined maximum of 100 prior authorized visits per calendar year)		
• Home health and home infusion care	10%	10% <sup>1</sup>

An Independent Member of the Blue Shield Association

Covered Services	Member Copayment	
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**OTHER**

**Hospice**<sup>6</sup> (\$10,000 maximum per member per lifetime)

- |   |     |                  |
|---|-----|------------------|
| • Routine home care and inpatient respite care            | 10% | 10% <sup>1</sup> |
| • 24 hour continuous home care and general inpatient care | 10% | 10% <sup>1</sup> |

**Alternative care**

- |  |                      |                                   |
|--|----------------------|-----------------------------------|
| • Chiropractic services (Up to 26 visits per calendar year) <sup>7</sup> | 10% up to \$50/visit | 50% <sup>1</sup> up to \$25/visit |
| • Acupuncture services   | 10%                  | 50% <sup>1</sup>                  |

**Rehabilitative therapy services**

- |   |     |                  |
|---|-----|------------------|
| • Outpatient visits (Medically Necessary) | 10% | 50% <sup>1</sup> |
|---|-----|------------------|

**Pregnancy and maternity care**

- |  |  |                  |
|--|--|------------------|
| • Prenatal and postnatal professional (physician) services<br>(For all necessary inpatient hospital services, see "Hospitalization Services.") | \$10/visit <sup>1</sup><br>(Deductible Waived) | 50% <sup>1</sup> |
|--|--|------------------|

**Family planning**

- |  |     |                  |
|--|-----|------------------|
| • Family planning counseling                   | 10% | 50% <sup>1</sup> |
| • Elective abortion, tubal ligation, vasectomy | 10% | 50% <sup>1</sup> |

**Covered out-of-state benefits** Benefits provided through BlueCard<sup>®</sup> 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.

**Diabetes care**

- |   |  |                  |
|---|--|------------------|
| • Equipment, devices and non-testing supplies | 10%  | 50% <sup>1</sup> |
| • Self-management training and education      | \$10/visit <sup>1</sup><br>(Deductible Waived) | 50% <sup>1</sup> |

**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 Deductible and copayments marked with a (1) 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 Evidence of Coverage, the Disclosure Form and the Plan Contract for exact terms and conditions of coverage.

2 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.

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 all charges in excess of \$580.

5 Requires prior authorization for benefits over \$500.

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

7 All chiropractic visits accrue to the calendar-year visit maximum regardless of whether the plan deductible has been met.

8 Member is responsible for an additional 25% penalty before the plan pays 90% of the allowable amount.

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