# Benefit Summary

(Uniform Health Plan Benefits and Coverage Matrix)

**SISC Custom ASO PPO SM Savings - Plan B**

**Blue Shield of California**

Effective October 1, 2012

## Calendar Year Medical Deductible

(All providers combined)

Note: For an individual on family coverage plan, enrollee can receive benefits for covered services once Individual deductible is met.

<table>
<thead>
<tr>
<th>Preferred Providers</th>
<th>Non-Preferred Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,500 per Individual / $5,000 per Family</td>
<td></td>
</tr>
</tbody>
</table>

## Calendar Year Out-of-Pocket Maximum

(Includes the plan deductible)

Note: For an individual on family coverage plan, enrollee can receive 100% benefits for covered services once individual out-of-pocket maximum is met.

<table>
<thead>
<tr>
<th>Preferred Providers</th>
<th>Non-Preferred Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>$5,000 per Individual / $10,000 per Family</td>
<td></td>
</tr>
</tbody>
</table>

## LIFETIME BENEFIT MAXIMUM

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Member Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Professional Benefits</strong></td>
<td>Preferred Providers</td>
</tr>
<tr>
<td>Physician and specialist office visits</td>
<td>10%</td>
</tr>
<tr>
<td>CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine(^2) (prior authorization is required)</td>
<td>10%</td>
</tr>
<tr>
<td>Other outpatient X-ray, pathology and laboratory (Diagnostic testing by providers other than outpatient laboratory, pathology, and imaging departments of hospitals/facilities)(^2)</td>
<td>10%</td>
</tr>
<tr>
<td><strong>Allergy Testing and Treatment Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>Office visits (includes visits for allergy serum injections)</td>
<td>10%</td>
</tr>
<tr>
<td><strong>Preventive Health Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>Preventive Health Services (As required by applicable federal law.)</td>
<td>No charge</td>
</tr>
</tbody>
</table>

## OUTPATIENT SERVICES

### Hospital Benefits (Facility Services)

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 plan payment per day.

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Member Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient surgery performed at an Ambulatory Surgery Center(^3)</td>
<td>10%</td>
</tr>
<tr>
<td>Outpatient surgery in a hospital</td>
<td>10%</td>
</tr>
<tr>
<td>Outpatient Services for treatment of illness or injury and necessary supplies (Except as described under “Rehabilitation Benefits”)</td>
<td>10%</td>
</tr>
<tr>
<td>CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine performed in a hospital (prior authorization is required)(^3)</td>
<td>10%</td>
</tr>
<tr>
<td>Other outpatient X-ray, pathology and laboratory performed in a hospital(^2)</td>
<td>10%</td>
</tr>
<tr>
<td>Bariatric Surgery(^4) (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only)</td>
<td>10%</td>
</tr>
</tbody>
</table>
### Hospitalization Services

**Hospital Benefits (Facility Services)**

- **Inpatient Physician Services**: 10% 22
- **Inpatient Non-emergency Facility Services** (semi-private room and board, and medically-necessary Services and supplies, including Subacute Care): 10% 50%
- **Bariatric Surgery** (prior authorization required by the Plan; medically necessary surgery for weight loss; for morbid obesity only): 10% No charge 5

**Skilled Nursing Facility Benefits**

(Combined maximum of up to 100 prior authorized days per Calendar Year; semi-private accommodations)

- **Services by a free-standing Skilled Nursing Facility**: 10% 10% 6
- **Skilled Nursing Unit of a Hospital**: 10% No charge 5

### 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 + 10% $100 per visit + 10%
- **Emergency room Services resulting in admission** *(when the member is admitted directly from the ER)*: 10% 10%
- **Emergency room Physician Services**: 10% 10%

### Ambulance Services

- **Emergency or authorized transport**: 10% 10%

### Prescription Drug Coverage

*(Subject to deductible; includes covered diabetic drugs and testing supplies)*

**Outpatient Prescription Drug Benefits**

**Retail Prescriptions** *(For up to a 30-day supply)*

- Formulary Generic Drugs: $7 per prescription
- Formulary Brand Name Drugs: $25 per prescription

**Mail Service Prescriptions** *(For up to a 90-day supply)*

- Formulary Generic Drugs: $14 per prescription
- Formulary Brand Name Drugs: $60 per prescription

**Specialty Pharmacies** *(up to a 30-day supply)*

- Specialty Drugs: $25 per prescription

**Participating Pharmacy**

- Prosthetic equipment and devices *(Separate office visit copay may apply)*: 10% 50%
- Orthotic equipment and devices *(Separate office visit copay may apply)*: 10% 50%

**Non-Participating Pharmacy**

- Durable Medical Equipment: 10% 50%

### Mental Health Services (Psychiatric)

- Inpatient Hospital Services: 10% No charge 5
- Outpatient Mental Health Services: 10% 50%

### Chemical Dependency Services (Substance Abuse)

- Inpatient Hospital Services: 10% No charge 5
- **Outpatient Chemical dependency and substance abuse services**: 10% 50%

### Home Health Services

- **Home health care agency Services** *(up to 100 prior authorized visits per Calendar Year)*: 10% Not Covered 17
- **Home infusion/home intravenous injectable therapy and infusion nursing visits provided by a Home Infusion Agency**: 10% Not Covered 17

### Other

**Hospice Program Benefits**

- **Routine home care**: 10% Not Covered 17
- **Inpatient Respite Care**: 10% Not Covered 17
- **24-hour Continuous Home Care**: 10% Not Covered 17
- **General Inpatient care**: 10% Not Covered 17
Chiropractic Benefits
- Chiropractic Services (provided by a chiropractor) (up to 20 visits per Calendar Year) 10% 50%

Acupuncture Benefits
- Acupuncture (up to 12 visits per Calendar Year) (maximum plan payment of $30 per visit) 10% 10%

Rehabilitation Benefits (Physical, Occupational and Respiratory Therapy)
- Office location 10% 50%

Speech Therapy Benefits
- Office location 10% 50%

Pregnancy and Maternity Care Benefits
- Prenatal and postnatal Physician office visits (For inpatient hospital services, see “Hospitalization Services.”) 10% 50%

Family Planning Benefits
- Counseling and consulting 10% Not Covered (Not subject to the Calendar-Year Deductible)
- Tubal ligation 10% Not Covered (Not subject to the Calendar-Year Deductible)
- Elective abortion 10% Not Covered (Not subject to the Calendar-Year Deductible)
- Vasectomy 10% Not Covered

Diabetes Care Benefits
- Devices, equipment, and non-testing supplies (for testing supplies see Outpatient Prescription Drug Benefits.) 10% 50%
- Diabetes self-management training (if billed by your provider, you will also be responsible for the office visit copayment) 10% 50%

Hearing Aid
- Audiological evaluations 10% 50%
- Hearing Aid (Maximum combined benefit of $700 per person every 24 months for hearing aid and ancillary equipment) 10% 10%

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 in excess of the allowable amount do not count toward the calendar-year deductible or out-of-pocket maximum. Payments applied to your Calendar Year Deductible accrue towards the Maximum Calendar Year Out-of-Pocket Responsibility.

2 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.

3 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.

4 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.

5 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 maximum plan payment per day.

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

7 This plan’s prescription drug coverage is on average equivalent to or better than the standard benefit set by the federal government for Medicare Part D (also called creditable coverage). Because this plan’s prescription drug coverage is creditable, you do not have to enroll in a Medicare prescription drug plan while you maintain this coverage. However, you should be aware that if you have a subsequent break in this coverage of 63 days or more anytime after you were first eligible to enroll in a Medicare prescription drug plan, you could be subject to a late enrollment penalty in addition to your Part B premium.

8 If the member requests a brand-name drug when a generic drug equivalent is available, the member is responsible for paying the difference between the cost to Blue Shield for the brand-name Drug and its generic drug equivalent, as well as the applicable generic drug Copayment. This difference in cost that the member must pay is not applied to their calendar-year medical deductible and is not included in the calendar-year out-of-pocket maximum responsibility calculations. Please note that if you switch from another plan, your prescription drug deductible credit from the previous plan during the calendar year, if applicable, will not carry forward to your new plan.

9 For the Outpatient Prescription Drugs Benefit, covered Drugs obtained from Non-Participating Pharmacies will be subject to and accrue to the Calendar Year Deductible and the Calendar Year Out-Of-Pocket Maximum for Preferred Providers.

10 Specialty drugs are covered only when dispensed by select pharmacies in the Specialty Pharmacy Network unless Medically Necessary for a covered emergency.

11 Selected formulary and non-formulary Drugs require prior authorization by Blue Shield for Medical Necessity, and when effective, lower cost alternatives are available.

12 Specialty Drugs are Specific Drugs used to treat complex or chronic conditions which usually require close monitoring such as multiple sclerosis, hepatitis, rheumatoid arthritis, cancers, and other conditions that are difficult to treat with traditional therapies. Specialty Drugs are listed in the Blue Shield Outpatient Drug Formulary. Specialty Drugs may be self-administered in the home by injection by the patient or family member (subcutaneously or intramuscularly), by inhalation, orally or topically. Infused or Intravenous (IV) medications are not included as Specialty Drugs. These Drugs may also require special handling, special manufacturing processes, and may have limited prescribing or limited pharmacy availability. Specialty Drugs must be considered safe for self-administration by Blue Shield’s Pharmacy & Therapeutics Committee, be obtained from a Blue Shield Specialty Pharmacy and may require prior authorization for Medical Necessity by
Blue Shield.

Select contraceptives, including diaphragms, covered under the outpatient prescription drug benefits will no longer require a copayment and will not be subject to the calendar-year deductible. However, if a brand-name select contraceptive is requested when a generic equivalent is available, the member will still be responsible for paying the difference between the cost to the Plan for the brand-name contraceptive and its generic drug equivalent, as well as the applicable generic drug copayment. In addition, select contraceptives may need prior authorization.

Mental health and chemical dependency services are accessed through Blue Shield’s using Blue Shield participating and non-participating providers.

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.

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.

Services with day or visit limits accrue to the calendar-year day or visit limit maximum regardless of whether the plan deductible has been met.

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

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.

The $350 per day maximum for non-preferred hospital services does not apply to Outpatient Services for treatment of illness or injury and necessary supplies.

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.