SISC ASO
Blue Shield of California 100% Plan G $20 Copayment
Benefit Summary
(Uniform Health Plan Benefits and Coverage Matrix)

Blue Shield of California

Effective: October 1, 2018

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.

Highlights: A description of the prescription drug coverage is provided separately

	Participating Providers[1]	Non-Participating Providers[2]
Calendar Year Medical Deductible All providers combined	$500 per individual / $1,000 per family	
Calendar Year Out-of-Pocket Maximum[12] Includes the Calendar Year medical deductible.	$1,000 per individual / $3,000 per family	
Lifetime Benefit Maximum	None	
Covered Services	**Member Copayment**	
OUTPATIENT PROFESSIONAL SERVICES	**Participating Providers[1]**	**Non-Participating Providers[2]**
Professional (Physician) Benefits		
Physician and Specialist office visits	$20 per visit (not subject to the Calendar Year Deductible)	50%[12]
Outpatient diagnostic x-ray, imaging, pathology, laboratory and other testing services	No Charge	Not Covered
Radiological and nuclear imaging (CT scans, MRIs, MRAs, PET scans and cardiac diagnostic procedures utilizing nuclear medicine)	No Charge	50%[12]
Allergy Testing and Treatment Benefits		
Allergy testing, treatment and serum injections (separate office visit copayment may apply)	No Charge	50%[12]
Preventive Health Benefits[11]		
Preventive health services (as required by applicable Federal law)	No Charge (not subject to the Calendar Year Deductible)	Not Covered
OUTPATIENT FACILITY SERVICES		
Outpatient surgery performed at a free-standing ambulatory surgery center	No Charge	No Charge[3]
Outpatient surgery performed in a hospital or a hospital affiliated ambulatory surgery center[14]	No Charge[14]	No Charge[3]
Outpatient services and supplies[14]	No Charge[14]	No Charge[3]
Outpatient services for treatment of illness or injury and necessary supplies (except as described under "Rehabilitation Benefits" and "Speech Therapy Benefits")	No Charge	50%[3,12]
Outpatient diagnostic x-ray, imaging, pathology, laboratory and other testing services[14]	No Charge[14]	Not Covered
Radiological and nuclear imaging (CT scans, MRIs, MRAs, PET scans and cardiac diagnostic procedures utilizing nuclear medicine)	No Charge	50%[3,12]
Bariatric surgery (prior authorization is required; medically necessary surgery for weight loss, for morbid obesity only)[4]	No Charge	No Charge[3]
HOSPITALIZATION SERVICES		
Hospital Benefits (Facility Services)		
Inpatient physician services	No Charge	50%[12,13]
Inpatient non-emergency facility services (semi-private room and board, and medically necessary services and supplies, including subacute care)	No Charge	No Charge[5]
Bariatric surgery (prior authorization is required; medically necessary surgery for weight loss, for morbid obesity only)[4]	No Charge	No Charge[5]
Inpatient Skilled Nursing Benefits[6] (Coverage limited to 100 days per member per benefit period combined with hospital/free-standing skilled nursing facility)		
Free-standing skilled nursing facility	No Charge	No Charge[7]
Skilled nursing unit of a hospital	No Charge	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	$100 per visit
Emergency room services resulting in admission (when the member is admitted directly from the ER)	No Charge	No Charge
Emergency room physician services	No Charge	No Charge[13]
AMBULANCE SERVICES		
Emergency or authorized transport (ground or air)	$100 per transport	$100 per transport
PRESCRIPTION DRUG COVERAGE		
Outpatient Prescription Drug Benefits	**Administered by Navitus Health Solutions 1-866-333-2757**	
PROSTHETICS/ORTHOTICS		
Prosthetic equipment and devices (separate office visit copayment may apply)	No Charge	50%[12]
Orthotic equipment and devices (separate office visit copayment may apply)	No Charge	Not Covered
DURABLE MEDICAL EQUIPMENT		
Breast pump	No Charge (not subject to the Calendar Year Deductible)	Not Covered
Other durable medical equipment	No Charge	Not Covered
MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES[8, 9]		
Inpatient hospital services	No Charge	No Charge[5]
Residential care	No Charge	No Charge[5]
Inpatient physician services	No Charge	50%[12,13]
Routine outpatient mental health and substance use disorder services (includes professional/physician visits)	$20 per visit (not subject to the Calendar Year Deductible)	50%[12]
Non-routine outpatient mental health and substance use disorder services (includes behavioral health treatment, electroconvulsive therapy, intensive outpatient programs, office-based opioid treatment, partial hospitalization program, psychological testing and transcranial magnetic stimulation)	No Charge	50%[12]
HOME HEALTH SERVICES		
Home health care agency services[6] (Coverage limited to 100 visits per member per calendar year)	No Charge	Not Covered[10]
Home infusion/home injectable therapy and infusion nursing visits provided by a home infusion agency	No Charge	Not Covered[10]
HOSPICE PROGRAM BENEFITS		
Routine home care	No Charge (not subject to the Calendar Year Deductible)	Not Covered[10]
Inpatient respite care	No Charge (not subject to the Calendar Year Deductible)	Not Covered[10]
24-hour continuous home care	No Charge (not subject to the Calendar Year Deductible)	Not Covered[10]
Short-term inpatient care for pain and symptom management	No Charge (not subject to the Calendar Year Deductible)	Not Covered[10]
CHIROPRACTIC BENEFITS[6]		
Chiropractic spinal manipulation (Coverage limited to 20 visits per calendar year.)	No Charge	Not Covered
ACUPUNCTURE BENEFITS[6]		
Acupuncture services (Coverage limited to 12 visits per calendar year.)	No Charge	50%[12]
REHABILITATION AND HABILITATION BENEFITS (Physical, Occupational and Respiratory Therapy)		
Office location (an additional facility copayment may apply when services are rendered in a hospital or skilled nursing facility)	No Charge	Not Covered
SPEECH THERAPY BENEFITS		
Office location (an additional facility copayment may apply when services are rendered in a hospital or skilled nursing facility)	No Charge	50%[12]
PREGNANCY AND MATERNITY CARE BENEFITS		
Prenatal and postnatal physician office visits (when billed as part of global maternity fee including hospital inpatient delivery services)	$20 per visit (not subject to the Calendar Year Deductible)	50%[12]
Abortion services (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)	No Charge	Not Covered

FAMILY PLANNING BENEFITS		
Counseling and consulting (includes insertion of IUD, as well as injectable and implantable contraceptives for women)	No Charge (not subject to the Calendar Year Deductible)	Not Covered
Tubal ligation	No Charge (not subject to the Calendar Year Deductible)	Not Covered
Vasectomy (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)	No Charge	Not Covered
DIABETES CARE BENEFITS		
Devices, equipment, and non-testing supplies (for testing supplies see Outpatient Prescription Drug Benefits)	No Charge	50%[12]
Diabetes self-management training	$20 per visit (not subject to the Calendar Year Deductible)	50%[12]
HEARING BENEFITS		
Audiological evaluations	$20 per visit (not subject to the Calendar Year Deductible)	50%[12]
Hearing aid instrument and ancillary equipment (Up to a maximum combined benefit of $700 per person every 24 months for the hearing aid and ancillary equipment.)	No Charge	No Charge
CARE OUTSIDE OF PLAN SERVICE AREA Benefits provided through the BlueCard® Program are paid at the Participating level. Member's cost share will be either a copayment or coinsurance based on the lower of billed charges or the negotiated allowable amount for Participating providers as agreed upon with the local Blue's Plan.		
Within US: BlueCard Program	See Applicable Benefit	See Applicable Benefit
Outside of US: BlueCard Worldwide	See Applicable Benefit	See Applicable Benefit

1 Unless otherwise specified, copayments/coinsurance are calculated based on allowable amounts. After the calendar year medical deductible is met, the member is responsible for copayments/coinsurance for covered services from participating providers. Participating providers agree to accept Blue Shield's allowable amount plus any applicable member copayment or coinsurance as full payment for covered services.

2 Non-participating providers can charge more than Blue Shield's allowable amounts. When members use non-participating providers, they must pay the applicable deductibles, copayments or coinsurance plus any amount that exceeds Blue Shield's allowable amount. Charges above the allowable amount do not count toward the calendar year deductible or out-of-pocket maximum.

3 The maximum allowed charges for non-emergency surgery performed in a non-participating ambulatory surgery center or outpatient unit of a non-participating hospital is $350 per day. Members are responsible for all charges in excess of $350.

4 Bariatric surgery is covered when prior 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 participating provider and there is no coverage for bariatric services from non-participating providers. In addition, if prior authorized by Blue Shield, 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 details.

5 The maximum allowed charges for non-emergency hospital services received from a non-participating hospital is $600 per day. Members are responsible for all charges in excess of $600.

6 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 calendar year medical deductible has been met.

7 Services may require prior authorization. When services are prior authorized, members pay the participating provider amount.

8 Mental health and Substance use disorder services are accessed through Blue Shield's participating and non-participating providers.

9 Inpatient services for acute detoxification are covered under the medical benefit; see the Hospital Benefits (Facility Services) section of the Plan Contract for benefit details. Services for acute medical detoxification are accessed through Blue Shield using Blue Shield's participating providers or non-participating providers.

10 Services from non-participating providers for home health care and hospice services are not covered unless prior authorized. When these services are prior authorized, the member's copayment or coinsurance will be calculated at the participating provider level, based upon the agreed upon rate between Blue Shield and the agency.

11 Preventive Health Services, including an annual preventive care or well-baby care office visit, are not subject to the calendar year medical deductible. Other covered non-preventive services received during, or in connection with, the preventive care or well-baby care office visit are subject to the calendar year medical deductible and applicable member copayment/coinsurance.

12 Copayments/coinsurance marked with this footnote do not accrue to the calendar year out-of-pocket maximum. Copayments/coinsurance and charges for services not accruing to the member's calendar year out-of-pocket continue to be the member's responsibility after the calendar year out-of-pocket maximum is reached. This amount could be substantial. Please refer to the Plan Contract for exact terms and conditions of coverage.

13 When these services are rendered by a non-participating Radiologist, Anesthesiologist, Pathologist and/or Emergency Room Physician in a participating facility, the member pays the participating provider copayment.

14 The maximum allowed charges for non-emergency outpatient services received from a participating outpatient hospital are listed below.

- Arthroscopy limited to $4,500 per visit
- Cataract Surgery limited to $2,000 per visit
- Colonoscopy limited to $1,500 per visit
- Upper GI Endoscopy with Biopsy limited to $1,250 per visit
- Upper GI Endoscopy limited to $1,000 per visit

Members are responsible for the applicable deductibles, copayments or coinsurance, plus all charges in excess of these maximums.

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

Navitus MedicareRx (PDP) Prescription Drug Plan for Self-Insured Schools of California – PDP200D0X35

Benefit Structure

Retail Network Pharmacy	Up to 90 Days
Mail Order Pharmacy	Up to 90 Days
Specialty Pharmacy (Marked NDS)	Up to 30 Days
Long Term Care Pharmacy	Up to 31 Days

The cost sharing structure may differ based on the pharmacy's status as preferred or non-preferred; mail order; long term care; home infusion; 30 vs. 90-day supplies; and your Medicare phase. Cost sharing may change when entering the catastrophic phase for Medicare Part D (PDP).

Cost Sharing Tiers
Tier 1 – Formulary Preferred Generics and Some Lower Cost Brand Products
Tier 2 – Formulary Preferred Brand Products and Some High Cost Non-preferred Generics (Includes All Formulary Specialty Products)

Self-Insured Schools of California Plan Annual Deductible Amount	
Applies to Tier 2 Drugs	**$200**

Retail and Mail Order Pharmacy Benefits

Benefit Structure	Retail Network (Up to 30 Days)	Retail Out-of-Network (Limited to 10 Days)	Retail Network (Extended Supply 31-60 Days)	Retail Network (Extended Supply 61-90 Days)	Network Mail Order (Up to 90 Days)
Tier 1 Cost Share	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment
Tier 2 Cost Share	$35 copayment	$35 copayment	$70 copayment	$105 copayment	$90 copayment

Extended supplies (greater than a 30 day supply) may not be available for all medications. To verify if one of your medications is excluded from extended supplies, check the Formulary. Medications which do **not** qualify for extended supplies will be marked with "NDS".