

SISC  
 Blue Shield of California 100%  
 Plan D - \$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

<b>Calendar year Medical Deductible<sup>2</sup></b> (All providers combined) (4 <sup>th</sup> quarter carryover applies)	<b>Preferred Providers<sup>1</sup></b>	<b>Non-Preferred Providers<sup>1</sup></b>
	\$300 per individual	\$600 per family
<b>Calendar year Copayment Maximum<sup>2</sup></b>	None	
<b>LIFETIME BENEFIT MAXIMUM</b>	None	

Covered Services	Member Copayment	
	Preferred Providers <sup>1</sup>	Non-Preferred Providers <sup>1</sup>

**PROFESSIONAL SERVICES**

**Professional (Physician) Benefits**

• Physician and specialist office visits	\$30 per visit <sup>5</sup>	50%
• Diagnostic testing	No charge	50%
• Outpatient X-ray, pathology and laboratory (Diagnostic testing by providers other than outpatient laboratory, pathology, and imaging departments of hospitals/facilities) <sup>3</sup>	No charge	50%

**Allergy Testing and Treatment Benefits**

• Office visits (includes visits for allergy serum injections)	No charge	50%
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**Preventive Health Benefits**

• Annual routine physical examination, vision and hearing screening and immunizations	No charge <sup>5</sup>	Not covered
• Routine laboratory services, including annual mammography, Papanicolaou test, or cervical cancer and human papillomavirus (HPV) screening (One per calendar year)	No charge <sup>5</sup>	50%
• Well baby care (Includes: eye/ear screenings, immunizations, vaccinations)	No charge <sup>5</sup>	50%
• Well baby laboratory	No charge <sup>5</sup>	50%

**OUTPATIENT SERVICES**

**Hospital Benefits (Facility Services)**

• Outpatient surgery performed at an Ambulatory Surgery Center <sup>3</sup>	No charge	No charge <sup>12</sup> (up to \$350 per day maximum payment)
• Outpatient surgery in a hospital	No charge	No charge <sup>12</sup> (up to \$350 per day maximum payment)
• Outpatient Services for treatment of illness or injury and necessary supplies (Except as described under "Rehabilitation benefits")	No charge	50%
• Outpatient X-ray, pathology and laboratory performed in a hospital <sup>3</sup>	No charge	50% <sup>12</sup> (up to \$350 per day maximum payment)
• Outpatient diagnostic testing performed in a hospital <sup>3</sup>	No charge	50% <sup>12</sup> (up to \$350 per day maximum payment)
• Bariatric Surgery (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity) <sup>4</sup>	No charge	No charge <sup>12</sup> (up to \$350 per day maximum payment)

**HOSPITALIZATION SERVICES**

**Hospital Benefits (Facility Services)**

• Inpatient Physician Services	No charge	50% <sup>13</sup>
• Inpatient Non-emergency Facility Services (Semi-private room and board, medically necessary services and supplies)	No charge	No charge <sup>12</sup> (up to \$600 per day maximum payment)
• Bariatric Surgery (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity) <sup>4</sup>	No charge	No charge <sup>12</sup> (up to \$600 per day maximum payment)

**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	No charge	No charge <sup>6</sup>
• Skilled Nursing Unit of a Hospital	No charge	No charge <sup>12</sup> (up to \$600 per day maximum payment)

An Independent member of the Blue Shield Association

<b>EMERGENCY HEALTH COVERAGE</b>		
• Emergency room Services not resulting in admission	\$100	\$100
• 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 <sup>13</sup>
<b>AMBULANCE SERVICES</b>		
• Emergency or authorized transport	No charge	No charge
<b>PRESCRIPTION DRUG COVERAGE</b>		
<b>Outpatient Prescription Drug Benefits</b>	<b>Administered by Medco</b>	
<b>PROSTHETICS/ORTHOTICS</b>		
• Prosthetic equipment and devices (Separate office visit copay may apply)	No charge	50%
• Orthotic equipment and devices (Separate office visit copay may apply)	No charge	50%
<b>DURABLE MEDICAL EQUIPMENT</b>		
• Durable Medical Equipment	No charge	50%
<b>MENTAL HEALTH SERVICES (PSYCHIATRIC)<sup>7</sup></b>		
• Inpatient Hospital Services	No charge	No charge <sup>12</sup> (up to \$600 per day maximum payment)
• Outpatient Mental Health Services	\$30 per visit <sup>5</sup>	50%
<b>CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)<sup>8</sup></b>		
• Inpatient Hospital Services	No charge	No charge <sup>12</sup> (up to \$600 per day maximum payment)
• Outpatient Chemical Dependency and Substance Abuse Services	\$30 per visit <sup>5</sup>	50%
<b>HOME HEALTH SERVICES<sup>9</sup></b>		
• Home health care agency Services (Maximum of 100 prior authorized visits per Calendar Year)	No charge	Not covered <sup>9</sup>
• Home infusion/home intravenous injectable therapy and infusion nursing visits provided by a Home Infusion Agency	No charge	Not covered <sup>9</sup>
<b>OTHER</b>		
<b>Hospice Program Benefits<sup>9</sup></b>		
• Routine home care	No charge	Not covered <sup>9</sup>
• Inpatient Respite Care	No charge	Not covered <sup>9</sup>
• 24-hour Continuous Home Care	No charge	Not covered <sup>9</sup>
• General Inpatient care	No charge	Not covered <sup>9</sup>
<b>Chiropractic Benefits<sup>10</sup></b>		
• Chiropractic Services - provided by a chiropractor (Up to 20 visits per calendar year)	No charge	50%
<b>Acupuncture Benefits<sup>10</sup></b>		
• Acupuncture (Up to 12 visits per calendar year)	No charge (Maximum plan payment of \$50 per visit)	No charge (Maximum plan payment of \$50 per visit)
<b>Rehabilitation Benefits (Physical, Occupational and Respiratory Therapy)</b>		
• Office location	No charge	50%
<b>Speech Therapy Benefits</b>		
• Office location	No charge	50%
<b>Pregnancy and Maternity Care Benefits</b>		
• Prenatal and Postnatal Physician Office Visits (For inpatient hospital services, see "Hospitalization Services.")	\$30 per visit <sup>5</sup>	50%
<b>Family Planning Benefits</b>		
• Counseling and consulting	No charge	Not covered
• Elective abortion <sup>11</sup>	No charge	Not covered
• Tubal ligation <sup>11</sup>	No charge	Not covered
• Vasectomy <sup>11</sup>	No charge	Not covered
<b>Diabetes Care Benefits</b>		
• Devices, equipment, and non-testing supplies	No charge	50%
• Diabetes self-management training (If billed by your provider, you will also be responsible for the office visit copayment)	\$30 per visit <sup>5</sup>	50%

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**Hearing Aid**

- Hearing Aid (Maximum combined benefit of \$700 per person every 24 months for hearing aid and ancillary equipment)

No charge

No charge

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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.

- Within US: BlueCard Program
- Outside of US: BlueCard Worldwide

See Applicable Benefit

See Applicable Benefit

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 100% 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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**SISC CO-PAYMENT REFERENCE GUIDE**

Medco manages your prescription drug benefit at the request of SISC. Your plan gives you the option of getting your covered medications through the **Medco Pharmacy™** mail-order service or at a participating retail pharmacy.

The chart below provides a summary of your prescription drug benefit co-payments.

<b>Type of medication</b>	<b>When you use a participating retail pharmacy, you pay:</b>	<b>When you use the Medco Pharmacy, you pay:</b>
Generic drugs	<b>\$10</b> co-payment (for up to a 30-day supply)	<b>\$25</b> co-payment (for up to a 90-day supply)
Brand-name drugs	<b>\$35</b> co-payment (for up to a 30-day supply)*	<b>\$90</b> co-payment (for up to a 90-day supply)*
Deductible <i>(applies to brand-name medications purchased at participating retail pharmacies and through mail order)</i>	<b>\$200</b> single/ <b>\$500</b> family (per calendar year beginning January 1)	<b>\$200</b> single/ <b>\$500</b> family (per calendar year beginning January 1)
<i>Please note: Any amount of deductible satisfied during the 4th quarter of the year will carry over to the following year.</i>		

*\*A generic drug will always be dispensed if one is available. If you purchase a brand-name drug when a generic alternative is available, you will pay the generic co-payment plus the difference in cost between the brand and the generic, even if your doctor writes “dispense as written” (DAW) on the prescription.*

When you visit a participating retail pharmacy and present your member ID card, you will pay the applicable cost share and receive up to a 30-day supply of the prescribed drug. For medication you take on an ongoing basis, using the **Medco Pharmacy** offers you convenience and potential cost savings. You can get more information about the **Medco Pharmacy** mail-order service by calling 1 800 MEDCO-MAIL (1 800 633-2662).

If you have Internet access, you can visit us online at **www.medco.com**. After registering, you can access information about your benefits, as well as health and wellness resources. You may also contact Member Services toll-free at 1 800 987-5241. Medco looks forward to meeting all of your prescription benefit needs.

(over, please)

## Medications that are not covered by your drug plan

Listed below are medications and medication categories that are not covered under your SISC drug plan. The list may not reflect all non-covered drugs and may be subject to change. To confirm whether a prescription drug you need to take is covered or to check the cost of a medication, visit [www.medco.com](http://www.medco.com) and click “Price a medication.” (If you’re a first-time visitor to the site, please take a moment to register. You’ll need your member ID number and the number from a recent prescription.) You can also get coverage and pricing information by calling Medco Member Services toll-free at 1 800 987-5241.

**Please note that this list may not be all-inclusive.**

- Anti-wrinkle agents (*Renova*®, *Retin-A*®, and *Avita*® for patients aged 36 and over)
- Experimental drugs
- Fertility medications (*Follistim*®, *Gonal-f*®, *Clomid*®, and *Repronex*®)
- Influenza treatments (for example, *Relenza*® and *Tamiflu*®)
- Medications labeled “Caution—limited by federal law to investigational use”
- Over-the-counter medications (except *Prilosec OTC*®)
- Pigmenting/depigmenting agents (hydroquinone, *Eldopaque*® and *Eldoquin*®)
- Hair growth and hair removal agents (*Propecia*® and *Vaniqa*®)
- Smoking-cessation agents (*Nicorette*®, *Zyban*®, *Chantix*™, and all nicotine patches)
- Vitamins (except prescription strengths of prenatal vitamins, hematinics, *Rocaltrol*® and other oral vitamin D)

(See the reverse side for your plan’s co-payment reference guide.)





# ARE YOU SAVING MONEY ON YOUR PRESCRIPTION MEDICATIONS?

*Don't miss your opportunity to save.*

## TAKE ADVANTAGE OF FREE GENERIC MEDICATIONS AT COSTCO

TO OBTAIN “FREE GENERICS” AT COSTCO:

- 1 Take your prescription for a generic medication to a Costco Pharmacy.
- 2 Present the pharmacist with your insurance card.
- 3 Get your generic medication with a **\$0 co-payment.**  
(excluding some narcotic pain medications and some cough medications)

*You do not have to be a Costco member  
to use their prescription pharmacy services.  
Just tell the associate at the front door you are going to their pharmacy.*

This Program is available to  
SISC members on  
participating drug plans.

To locate a Costco near you,  
call Costco at

1 (800) 774-2678  
and dial 1

