CSAC/EIA Health Small Group Program
Silver PPO 80/50
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. PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Blue Shield of California

Effective January 1, 2011

	Preferred Providers[2]	Non-Preferred Providers[2]
Calendar year Medical Deductible[1] (All providers combined)	$2,000 per individual/ $4,000 per family	
Calendar year Copayment Maximum[1] (Copayments for Preferred Providers accrue to both Preferred and Non-Preferred Provider Calendar-year Copayment Maximum amounts.)	$3,000 per individual/ $6,000 per family	
LIFETIME BENEFIT MAXIMUM	None	
Covered Services	**Member Copayment**	
PROFESSIONAL SERVICES	**Preferred Providers[2]**	**Non-Preferred Providers[2]**
Professional (physician) benefits		
• Physician and specialist office visits	$30 per visit (Not subject to the Calendar-Year Deductible)	50%
• Diagnostic testing	20%	50%
• Outpatient X-ray, pathology and laboratory	No charge (Not subject to the Calendar-Year Deductible)	50%
Allergy testing and treatment benefits		
• Office visits (includes visits for allergy serum injections)	20%	50%
Preventive health benefits		
• Annual routine physical examination office visit: including the physical examination office visit, routine eye/ear screening for members through age 18 and pediatric and adult immunizations and the immunization agent.	No charge (Not subject to the Calendar-Year Deductible)	Not covered
• Annual routine gynecological office visit: including the gynecological examination office visit, routine mammography, routine Papanicolaou (Pap) test or other FDA approved cervical cancer screening test ,human papillomavirus (HPV) screening tests (One per calendar year)	No charge (Not subject to the Calendar-Year Deductible)	Not covered
• Routine laboratory services, including well baby laboratory services.	No charge (Not subject to the Calendar-Year Deductible)	Not covered
• Well baby office visit: including well baby examination office visit, pediatric immunizations and the immunization agent, well baby vision and hearing screening	No charge (Not subject to the Calendar-Year Deductible)	Not covered
OUTPATIENT SERVICES		
Hospital benefits (facility services)		
The maximum allowed charges 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 50% of this $350 per day, plus all charges in excess of $350.		
• Outpatient surgery performed in an Ambulatory Surgery Center[3]	20%	50%
• Outpatient surgery in a hospital	20%	50%
• Outpatient services for treatment of illness or injury and necessary supplies (Except as described under "Rehabilitation benefits")	20%	50%
• Bariatric surgery (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity)[5]	20%	50%
HOSPITALIZATION SERVICES		
Hospital benefits (facility services)		
• Inpatient physician benefits	20%	50%
• Inpatient non-emergency facility services (semi-private room and board, medically necessary services and supplies)	20%	50%[4]
• Bariatric surgery (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity)[5]	20%	50%[4]
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	20%	20% with prior authorization[6]
• Skilled nursing facility unit of a hospital	20%	50%[4]

EMERGENCY HEALTH COVERAGE		
• Emergency room services not resulting in admission (If ER services do not result in a direct admission the Calendar-Year Deductible does not apply)	$50 per visit + 20%	$50 per visit + 20%
• Emergency room services resulting in admission (when the member is admitted directly from the ER)	20%	20%
• Emergency room physician services	20%	20%
AMBULANCE SERVICES		
• Emergency or authorized transport	20%	20%
PROSTHETICS/ORTHOTICS		
• Prosthetic equipment and devices (Separate office visit copay may apply)	20%	50%
• Orthotic equipment and devices (Separate office visit copay may apply)	20%	50%
DURABLE MEDICAL EQUIPMENT		
• Durable medical equipment	20%	50%
MENTAL HEALTH SERVICES (PSYCHIATRIC)[7]		
• Inpatient hospital services	20%	50%[4]
• Outpatient mental health services	$30 per visit (Not subject to the Calendar-Year Deductible)	50%
CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)[7]		
• Inpatient hospital services	20%	50%[4]
• Outpatient substance abuse services	$30 per visit (Not subject to the Calendar-Year Deductible)	50%
HOME HEALTH SERVICES[10]		
• Home health care agency services (Maximum of 100 prior authorized visits per calendar year)	20%	Not covered[10]
• Home infusion/Home injectable therapy provided by a home infusion agency	20%	Not covered[10]
OTHER		
Hospice program benefits[10]		
• Routine home care	20%	Not covered[10]
• Inpatient respite care	20%	Not covered[10]
• 24-hour continuous home care	20%	Not covered[10]
• General inpatient care	20%	Not covered[10]
Chiropractic benefits[8]		
• Chiropractic services – provided by a chiropractor (Up to 26 visits per calendar year combined with Acupuncture services)	20% (maximum plan payment of $50 per visit)	50% (maximum plan payment of $25 per visit)
Acupuncture benefits[8]		
• Acupuncture (Up to 26 visits per calendar year combined with Chiropractic services)	20%	20%
Rehabilitation benefits (physical, occupational and respiratory therapy)		
• Office location	20%	50%
Speech therapy benefits		
• Office location	20%	50%
Pregnancy and maternity care benefits		
• Prenatal and postnatal physician office visits (For inpatient hospital services, see "Hospitalization Services.")	20%	50%
Family planning benefits		
• Counseling and consulting	$30 per visit (Not subject to the Calendar-Year Deductible)	Not covered
• Elective abortion[9]	20%	Not covered
• Tubal ligation[9]	20%	Not covered
• Vasectomy[9]	20%	Not covered
Diabetes care benefits		
• Devices, equipment, and non-testing supplies	20%	50%
• Diabetes self-management training (If billed by your provider, you will also be responsible for the office visit copayment)	$30 per visit	50%
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/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 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 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 allowed charges for non-emergency hospital services received from a non-preferred hospital is $600 per day. Members are responsible for 50 percent of this $600 per day, plus all charges in excess of $600.

5 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.

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, Chemical dependency and acute detoxification services are accessed through Blue Shield - using Blue Shield's participating and non-participating providers. For a listing of severe mental illnesses, including serious emotional disturbances of a child, and other benefit details, please refer to the Plan Contract.

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

9 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.

10 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.

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