SECTION 3
SUMMARY OF ACTIVE PLAN BENEFITS
EFFECTIVE JANUARY 1, 2014

CALENDAR YEAR DEDUCTIBLES	DENTAL
1. $250 individual medical Deductible with $750 maximum family medical Deductible 2. $50 Dental Calendar Year Deductible per person (INCLUDED IN $250 CALENDAR YEAR DEDUCTIBLE) 3. $50 Prescription Drug Benefit Calendar Year Deductible per person (DOES NOT APPLY TO THE CALENDAR YEAR DEDUCTIBLE) 4. $50 Hearing Aid per device per person (DOES NOT APPLY TO THE CALENDAR YEAR DEDUCTIBLE)	1. 100% of Allowable Charge (per the Dental Fee Schedule, see Section 18) incurred up to a maximum of $1,800 per person per Calendar Year 2. Orthodontics $600 maximum per Calendar Year with a Lifetime Maximum of $1,800 (applies to $1,800 dental Calendar Year max) 3. Three cleanings per Calendar Year subject to the $50 Dental Calendar Year Deductible

USEFUL DEFINITIONS

Allowable Charge(s)
The scheduled amounts for medical and dental services and supplies are established by the Board of Trustees and Blue Shield of California. Any remaining amount that exceeds the Allowable Charge is not payable or recognized by the Plan for any purpose. The Patient is responsible for the co-payment amount, if any, and any charges that exceed the Allowable Charge.

Blue Shield of California Contract Rate
The dollar amount agreed upon between Blue Shield of California and the various providers of service. The Patient is responsible for the Copayment, if any.

Calendar Year
The period of January 1 through December 31.

Copayment
The portion of the Contract Rate or Allowable Charge, expressed as either a percentage or dollar amount that the Patient is responsible to pay.

Deductible
The amount the Patient is required to pay prior to the Plan paying any benefits. The Deductible is determined based on either the Contract Rate or the Allowable Charge, not necessarily the full billed amount.

Out-of-Pocket
The amount the Patient must pay for services and treatment that are not paid by the Plan. This includes, but is not limited to, Deductibles, percentage payable for services rendered, charges in excess of the Allowable Charge or Blue Shield of California Contract Rate and any non-covered services.

SUMMARY OF ACTIVE PLAN BENEFITS

Please see relevant section for details.

TYPE OF SERVICE		BLUE SHIELD OF CALIFORNIA (BSC) CONTRACTING PROVIDER Plan Pays:	NON-BLUE SHIELD OF CALIFORNIA CONTRACTING PROVIDER Any charges that exceed the Allowable Charge are Out-of-Pocket expenses to the Patient. Plan Pays:
AMBULANCE (Air and Ground)		80% of the Allowable Charge for professional ambulance or air ambulance services deemed Medically Necessary by the Plan.	
ANESTHESIA		100% of the BSC Contract Rate.	100% of the Allowable Charge.
CHEMOTHERAPY		95% of the BSC Contract Rate.	95% of the Allowable Charge.
CHIROPRACTOR		**Maximum 3 visits per week, 35 visits per Calendar Year (can be combination of contracted and non-contracted providers). Children under the age of 7 (seven) years require a referral to the Chiropractor by their attending physician.**	
		100% of the BSC Contract Rate.	100% of the Allowable Charge. Up to a maximum of $54.
DURABLE MEDICAL EQUIPMENT (The Plan NEVER purchases Durable Medical Equipment)		**Benefits paid on rental-to-purchase basis based on monthly eligibility of patient.**	
		95% of the BSC Contract Rate.	95% of the Allowable Charge.
HOSPITAL	**Hospital Inpatient**	95% of the BSC Contract Rate for all room and board and Medically Necessary services and supplies.	90% of the Allowable Charge for room and board and other Medically Necessary services and supplies up to $1,215 per day.
	Inpatient Psychiatric (goal oriented and substance abuse related mental illness not covered)	95% of the BSC Contract Rate for all room and board and Medically Necessary services.	90% of the Allowable Charge for room and board and other Medically Necessary services and supplies up to $1,215 per day.
	Hospital Outpatient	95% of the BSC Contract Rate.	90% of the Allowable Charge.
LABORATORY		100% of the BSC Contract Rate.	100% of the Allowable Charge.

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MEDICAL SUPPLIES		95% of the BSC Contract Rate.	95% of the Allowable Charge.
NON-PRESCRIPTION and OVER-THE-COUNTER DRUGS		**NOT COVERED**	
PAIN MANAGEMENT		• 100% of Hospital facility fee up to a maximum Allowable Charge of $900 per day; or • 100% of Surgery Center facility fee up to a maximum Allowable Charge of $800 per day; or • 100% of Physician's office/surgery suite facility fee up to a maximum Allowable Charge of $700 per day; and • Up to $250 per injection • Maximum of 3 injections per day	
PHYSICIAN	**Physician Visit**	100% of the BSC Contract Rate.	100% of Allowable Charge.
	Acupuncture (Must be performed by a Physician)	Office visit only 100% of the BSC Contract Rate.	Office visit only 100% of the Allowable Charge.
PRESCRIPTION **Benefits per Calendar year**		Prescription benefit is payable at 100% for the first $1,800, 50% of the next $4,200, and 65% of incurred expenses exceeding $6,000 in a Calendar Year per eligible individual. $50 Prescription Deductible (does not apply to the Calendar Year Deductible). Drugs or medications include oral contraceptives and up to 30 pills annually for the treatment of erectile dysfunction for Participant and Spouse only. Prescription Drug Benefits paid under the Pensioners & Surviving Spouses Health Fund will reduce Prescription Drug Benefits paid under the Health & Welfare Fund and vice versa.	

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PSYCHIATRIC	**OUTPATIENT PSYCHIATRIC** (must be referred by a Physician to a Psychiatrist, licensed Psychologist or doctor of psychology, clinical social worker, master social worker, or marriage counselor who is practicing within the scope of his/her license in the state in which he/she practices)	100% of the BSC Contract Rate.	100% of the Allowable Charge.
	INPATIENT PSYCHIATRIC Must be performed by a Physician. (Refer to Hospital Benefits)	100% of the BSC Contract Rate.	100% of the Allowable Charge up to $1,215 per day.
PHYSICAL THERAPY		100 % of the BSC Contract Rate for physical therapy services rendered in an Outpatient Hospital setting or Outpatient physical therapy facility.	100% up to a maximum Allowable Charge of $70 per visit for physical therapy services rendered in an Outpatient Hospital setting or Outpatient physical therapy facility.
RADIATION THERAPY		95% of the BSC Contract Rate.	95% of the Allowable Charge.
RADIOLOGY **(X-rays, CT scans, MRI/CAT scans, etc.)**	**Performed in an Outpatient radiology facility or Physician's office**	100% of the BSC Contract Rate.	100% of the Allowable Charge.
	Performed in a Hospital	95% of the BSC Contract Rate.	100% of the Allowable Charge.

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RENAL DIALYSIS	**Supplies**	95% of the BSC Contract Rate.	95% of the Allowable Charge.
	Facility	95% of the BSC Contract Rate	90% of maximum Allowable Charge up to $200 per visit.
SLEEP APNEA		100% of Surgeon and facility fee.	
SURGERY	**Primary Surgeon**	100% of the BSC Contract Rate.	100% of the Allowable Charge.
	Assistant Surgeon	20% of the BSC Surgeon's Contract Rate.	20% of the Surgeon's Allowable Charge.
	Second Assistant Surgeon	10% of the BSC Surgeon's Contract Rate.	10% of the Surgeon's Allowable Charge.
VISION CARE		Up to $200 for charges incurred in a 24-month period for examination, fittings, glasses and contact lenses. Exception: the Plan will pay for one examination per 12-month period and up to $200 for charges incurred in a 12-month period by dependent children to age 18 for fittings, glasses and contact lenses.	
WELL CHILD EXAMS & IMMUNIZATIONS TO AGE 17		Well Child Coverage after initial discharge from Hospital/birthing center at the time of birth to age 17.	