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Benefit Summary (For groups of 300 and above)
(Uniform Health Plan Benefits and Coverage Matrix)

Blue Shield of California

Effective: January 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 Covered services from Non-Participating providers accrue to both the Participating and Non-Participating provider Calendar Year deductible.	$500 per individual / $1,500 per family	$1,000 per individual / $3,000 per family
Calendar Year Out-of-Pocket Maximum Covered services from Non-Participating providers accrue to both the Participating and Non-Participating provider Calendar Year out-of-pocket.	$3,000 per individual / $6,000 per family	$6,000 per individual / $12,000 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	$30 per visit (not subject to the Calendar Year medical deductible)	40%
Teladoc consultation	No Charge (not subject to the Calendar Year medical deductible)	Not Covered
Outpatient diagnostic x-ray, imaging, pathology, laboratory and other testing services	20%	40%
Radiological and nuclear imaging (CT scans, MRIs, MRAs, PET scans and cardiac diagnostic procedures utilizing nuclear medicine)	20%	40%
Allergy Testing and Treatment Benefits		
Allergy testing, treatment and serum injections (separate office visit copayment may apply)	20%	40%
Preventive Health Benefits[11]		
Preventive health services (as required by applicable Federal law)	No Charge (not subject to the Calendar Year medical deductible)	40%
OUTPATIENT FACILITY SERVICES		
Outpatient surgery performed at a free-standing ambulatory surgery center	20%	40% up to $350 per day [3]
Outpatient surgery performed in a hospital or a hospital affiliated ambulatory surgery center	20%	40% up to $350 per day [3]
Outpatient services for treatment of illness or injury and necessary supplies (except as described under "Rehabilitation Benefits" and "Speech Therapy Benefits")	20%	40% up to $350 per day [3]
Outpatient diagnostic x-ray, imaging, pathology, laboratory and other testing services	20%	40% up to $350 per day [3]
Radiological and nuclear imaging (CT scans, MRIs, MRAs, PET scans and cardiac diagnostic procedures utilizing nuclear medicine)	20%	40% up to $350 per day [3]
Bariatric surgery	Not Covered	Not Covered
HOSPITALIZATION SERVICES		
Hospital Benefits (Facility Services)		
Inpatient physician services	20%	40%
Inpatient non-emergency facility services (semi-private room and board, and medically necessary services and supplies, including subacute care)	20%	40% up to $600 per day [5]
Bariatric surgery	Not Covered	Not Covered

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Inpatient Skilled Nursing Benefits[6] (Coverage limited to 60 days per member per benefit period combined with hospital/free-standing skilled nursing facility)		
Free-standing skilled nursing facility	20%	20% [7]
Skilled nursing unit of a hospital	20%	40% up to $600 per day [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 admission (not subject to the Calendar Year medical deductible)	$100 per admission (not subject to the Calendar Year medical deductible)
Emergency room services resulting in admission (when the member is admitted directly from the ER)	20%	40%
Emergency room physician services	20%	20%
URGENT CARE		
Urgent care center	$30 per visit (not subject to the Calendar Year medical deductible)	40%
AMBULANCE SERVICES		
Emergency or authorized transport (ground or air)	20%	20%
PRESCRIPTION DRUG COVERAGE		
Outpatient Prescription Drug Benefits A description of your outpatient prescription drug coverage is provided separately. If you do not have the separate drug summary that goes with this benefit summary, please contact your benefits administrator or call the Customer Service number on your identification card.		
PROSTHETICS/ORTHOTICS		
Prosthetic equipment and devices (separate office visit copayment may apply)	20%	40%
Orthotic equipment and devices (separate office visit copayment may apply)	20%	40%
DURABLE MEDICAL EQUIPMENT		
Breast pump	No Charge (not subject to the Calendar Year medical deductible)	40%
Other durable medical equipment	20%	40%
MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES[8, 9]		
Inpatient hospital services	20%	40% up to $600 per day [5]
Residential care	20%	40% up to $600 per day [5]
Inpatient physician services	20%	40%
Routine outpatient mental health and substance use disorder services (includes professional/physician visits)	$30 per visit (not subject to the Calendar Year medical deductible)	40%
Non-routine outpatient mental health and substance use disorder services (includes electroconvulsive therapy, intensive outpatient programs, office-based opioid treatment, partial hospitalization program, psychological testing and transcranial magnetic stimulation)	20%	40%
HOME HEALTH SERVICES		
Home health care agency services[6] (Coverage limited to 60 visits per member per calendar year)	20%	Not Covered [10]
Home infusion/home injectable therapy and infusion nursing visits provided by a home infusion agency	20%	Not Covered [10]
HOSPICE PROGRAM BENEFITS		
Routine home care	20%	Not Covered [10]
Inpatient respite care	20%	Not Covered [10]
24-hour continuous home care	20%	Not Covered [10]
Short-term inpatient care for pain and symptom management	20%	Not Covered [10]
CHIROPRACTIC BENEFITS[6]		
Chiropractic spinal manipulation (Coverage is limited to 20 visits per calendar year.)	$40 per visit (not subject to the Calendar Year medical deductible)	40%
ACUPUNCTURE BENEFITS[6]		
Acupuncture services (Coverage is limited to 20 visits per calendar year.)	$40 per visit (not subject to the Calendar Year medical deductible)	40%

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)	$30 per visit (not subject to the Calendar Year medical deductible)	40%
SPEECH THERAPY BENEFITS		
Office location (an additional facility copayment may apply when services are rendered in a hospital or skilled nursing facility)	$30 per visit (not subject to the Calendar Year medical deductible)	40%
PREGNANCY AND MATERNITY CARE BENEFITS		
Prenatal and postnatal physician office visits (when billed as part of global maternity fee including hospital inpatient delivery services)	No Charge (not subject to the Calendar Year medical deductible)	40%
Abortion services (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)	20%	40%
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 medical deductible)	Not Covered
Tubal ligation	No Charge (not subject to the Calendar Year medical deductible)	Not Covered
Vasectomy (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)	20%	40%
DIABETES CARE BENEFITS		
Devices, equipment, and non-testing supplies (for testing supplies see Outpatient Prescription Drug Benefits)	20%	40%
Diabetes self-management training	$30 per visit (not subject to the Calendar Year medical deductible)	40%
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 and services performed in a non-participating ambulatory surgery center or outpatient unit of a non-participating hospital is $350 per day. Members are responsible for 40% of this $350 per day, and all charges in excess of $350 per day. Amounts that exceed the benefit maximums do not count toward the calendar year out-of-pocket maximum and continue to be the member's financial responsibility after the calendar year maximums are reached.

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5 The maximum allowed charges for non-emergency hospital services received from a non-participating hospital is $600 per day. Members are responsible for 40% of this $600 per day, and all charges in excess of $600 per day. Amounts that exceed the benefit maximum do not count toward the calendar year out-of-pocket maximum and continue to be the member's responsibility after the calendar year maximums are reached.

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.

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

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Outpatient Prescription Drug Coverage
(For groups of 300 and above)

THE PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

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Highlight: $0 Calendar Year Pharmacy Deductible
$10 Tier 1 / $35 Tier 2 / $60 Tier 3 Drug – Retail Pharmacy
$20 Tier 1 / $70 Tier 2 / $120 Tier 3 Drug – Mail Service

Covered Services	Member Copayment	
DEDUCTIBLES (Prescription drug coverage benefits are not subject to the medical plan deductible.)		
Calendar Year Pharmacy Deductible	None	
PRESCRIPTION DRUG COVERAGE[1,3,4]	**Participating Pharmacy**	**Non-Participating Pharmacy**
Retail Prescriptions (up to a 30-day supply)		
• Contraceptive Drugs and Devices[2]	$0 per prescription	Not Covered
• Tier 1 drugs	$10 per prescription	Not Covered
• Tier 2 drugs	$35 per prescription	Not Covered
• Tier 3 drugs	$60 per prescription	Not Covered
• Tier 4 drugs (excluding Specialty drugs)	20% (up to $150 coinsurance maximum per prescription)	Not Covered
Mail Service Prescriptions (up to a 90-day supply)		
• Contraceptive Drugs and Devices[2]	$0 per prescription	Not Covered
• Tier 1 drugs	$20 per prescription	Not Covered
• Tier 2 drugs	$70 per prescription	Not Covered
• Tier 3 drugs	$120 per prescription	Not Covered
• Tier 4 drugs (excluding Specialty drugs)	20% (up to $300 coinsurance maximum per prescription)	Not Covered
Specialty Pharmacies (up to a 30-day supply)[5]		
• Tier 4 - Specialty Drugs[6]	20% (up to $150 maximum per prescription)	Not Covered

1 Amounts paid through copayments and any applicable pharmacy deductible accrues to the member's medical calendar year out-of-pocket maximum. Please refer to the Plan Contract for exact terms and conditions of coverage. Please note that if you switch from another plan, your prescription drug deductible credit, if applicable, from the previous plan during the calendar year will not carry forward to your new plan.

2 Contraceptive Drugs and Devices covered under the outpatient prescription drug benefits will not be subject to the applicable calendar year pharmacy deductible when obtained from a participating pharmacy. If a brand contraceptive is requested when a generic equivalent is available, the member will be responsible for paying the difference between the cost to Blue Shield for the brand contraceptive and its generic drug equivalent. In addition, select brand contraceptives may need prior authorization to be covered without a copayment.

3 Select drugs require prior authorization by Blue Shield for medical necessity, or when effective, lower cost alternatives are available.

4 If the member requests a brand drug when a tier 1 drug equivalent is available, the member is responsible for paying the difference in cost between the tier 2 drug and its tier 1 drug equivalent, in addition to the tier 1 drug copayment. The difference in cost that the member must pay does not accrue to any calendar year medical or tier 2 drug deductible and is not included in the calendar year out-of-pocket maximum responsibility calculations. Refer to the Plan Contract for details

5 Network Specialty Pharmacies dispense Specialty drugs which require coordination of care, close monitoring, or extensive patient training that generally cannot be met by a retail pharmacy. Network Specialty Pharmacies also dispense Specialty drugs requiring special handling or manufacturing processes, restriction to certain Physicians or pharmacies, or reporting of certain clinical events to the FDA. Specialty drugs are generally high cost.

6 Specialty drugs are available from a Network Specialty Pharmacy. A Network Specialty Pharmacy provides specialty drugs by mail or upon member request, at an associated retail store for pickup.

Note: 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 D premium.

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Important Prescription Drug Information

You can find details about your drug coverage three ways:

1. Check your *Plan Contract.*
2. Go to **https://www.blueshieldca.com/bsca/pharmacy/home.sp** and log onto My Health Plan from the home page.
3. Call Member Services at the number listed on your Blue Shield member ID card.

At Blue Shield of California, we're dedicated to providing you with valuable resources for managing your drug coverage. Go online to the *Pharmacy* section of **https://www.blueshieldca.com/bsca/pharmacy/home.sp** and select the *Drug Database and Formulary* to access a variety of useful drug information that can affect your out-of-pocket expenses, such as:

- Look up non-formulary drugs with formulary or generic equivalents;
- Look up drugs that require step therapy or prior authorization;
- Find specifics about your prescription copayments;
- Find local network pharmacies to fill your prescriptions.

TIPS!

Using the convenient mail service pharmacy can save you time and money. If you take a consistent dose of a covered maintenance drug for a chronic condition, such as diabetes or high blood pressure, you can receive up to a 90-day supply through the mail service pharmacy with a reduced copayment. Call the mail service pharmacy at (866) 346-7200. Members using TTY equipment can call TTY/TDD 866-346-7197.

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