Basic PPO for HSA (HSA-Compatible)

Uniform Health Plan Benefits and Coverage Matrix

Blue Shield of California

Effective January 1, 2014

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE *EVIDENCE OF COVERAGE* SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

This HSA-eligible PPO plan uses the Exclusive PPO provider network.

	Participating Providers[1]	Non-Participating Providers[1]
Calendar Year Medical Deductible[2] (For family coverage, there is no individual deductible. Enrolled family members receive benefits for covered services once the family deductible has been satisfied by one, or any combination of family members.)	$4,500 for individuals / $9,000 for families (all providers combined)	
Calendar Year Out-of-Pocket Maximum[3] (Includes the calendar year medical deductible. Copayments for participating providers apply to both participating and non-participating provider calendar year out-of-pocket maximum amounts.)	$6,350 for individuals / $12,700 for families	$9,350 for individuals / $18,700 for families
Calendar Year Brand Drug Deductible (Brand drugs are subject to the calendar year medical deductible)	$0	Not covered
Lifetime Benefit Maximum	None	

Covered Services	**Member Copayments**	
	Participating Providers[1]	**Non-Participating Providers**[1]
PROFESSIONAL SERVICES		
Professional (Physician) Benefits		
Physician office visits from internal medicine, family practice, pediatric, and OB/Gyn physicians	40%	50%
Specialist physician office visits	40%	50%
Outpatient diagnostic X-ray and imaging (non-hospital-based or -affiliated)	40%	50%
Outpatient diagnostic laboratory and pathology (non-hospital-based or -affiliated)	40%	50%
Preventive Health Benefits		
Preventive health services (as required by federal and California law)	$0[2]	Not covered
OUTPATIENT SERVICES		
Outpatient surgery in a hospital	40%	50%[4]
Outpatient surgery performed at an ambulatory surgery center	40%	50%[5]
Outpatient services for treatment of illness or injury and necessary supplies	40%	50%[4]
Outpatient diagnostic X-ray and imaging performed in a hospital	40%	50%[4]
Outpatient diagnostic laboratory and pathology performed in a hospital	40%	50%[4]
CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine (prior authorization is required)	40%	50%[6]
HOSPITALIZATION SERVICES		
Inpatient physician services	40%	50%
Inpatient non-emergency facility services (semi-private room and board, services and supplies, including subacute care)	40%	50%[4]
Bariatric surgery (prior authorization is required; medically necessary surgery for weight loss is for morbid obesity only)[7]	40%	Not covered
EMERGENCY HEALTH COVERAGE		
Emergency room services not resulting in admission	40%	40%
Emergency room services resulting in admission (when the member is admitted directly from the ER)	40%	40%

Covered Services	Member Copayments	
	Participating Providers[1]	**Non-Participating Providers**[1]
Emergency room physician services	40%	40%
Urgent care	40%	50%
AMBULANCE SERVICES		
Emergency or authorized transport (ground or air)	40%	40%
PRESCRIPTION DRUG COVERAGE[8,9,10]	**Participating Pharmacy**	**Non-Participating Pharmacy**
Retail Prescriptions (up to a 30-day supply)		
Contraceptive drugs and devices[9]	$0	Not covered
Generic drugs	40% per prescription	Not covered
Preferred brand drugs	40% per prescription	Not covered
Non-preferred brand drugs	40% per prescription	Not covered
Mail Service Prescriptions (up to a 90-day supply)		
Contraceptive drugs and devices[9]	$0	Not covered
Generic drugs	40% per prescription	Not covered
Preferred brand drugs	40% per prescription	Not covered
Non-preferred brand drugs	40% per prescription	Not covered
Specialty Pharmacies (up to a 30-day supply)		
Specialty drugs (May require prior authorization from Blue Shield. Specialty drugs are covered only when dispensed by Network Specialty Pharmacies. Drugs from non-participating pharmacies are not covered except in emergency and urgent situations.)	40%	Not covered
	Participating Providers[1]	**Non-Participating Providers**[1]
PROSTHETICS/ORTHOTICS		
Prosthetic equipment and devices (separate office visit copay may apply)	40%	50%
Orthotic equipment and devices (separate office visit copay may apply)	40%	50%
DURABLE MEDICAL EQUIPMENT		
Breast pump	$0[2]	Not covered
Other durable medical equipment	40%	50%
MENTAL HEALTH SERVICES[11]		
Inpatient hospital services (prior authorization required)	40%	50%[4]
Outpatient mental health services (some services may require prior authorization and facility charges)	40%	50%
SUBSTANCE ABUSE SERVICES[11]		
Inpatient hospital services for medical acute detoxification (prior authorization required)	40%	50%[4]
Outpatient substance abuse services (some services may require prior authorization and facility charges)	40%	50%
HOME HEALTH SERVICES		
Home health care agency services (up to 100 prior authorized visits per calendar year)	40%	Not covered (unless prior authorized)
OTHER		
Pregnancy and Maternity Care Benefits		
Prenatal physician office visits	$0[2]	50%
Postnatal physician office visits	40%	50%
Inpatient hospital services for normal delivery and cesarean section	40%	50%[4]
Family Planning Benefits		
Injectable and implantable contraceptives	$0[2]	Not covered
Counseling and consulting	$0[2]	Not covered
Tubal ligation	$0[2]	Not covered
Vasectomy	40%	Not covered
Elective abortion	40%	Not covered
Infertility services	Not covered	Not covered
Rehabilitation and Habilitation Benefits		
Office location	40%	50%
Outpatient department of a hospital	40%	50%[4]
Chiropractic Benefits		
Chiropractic services	Not covered	Not covered

Covered Services	Member Copayments	
	Participating Providers[1]	**Non-Participating Providers**[1]
Acupuncture Benefits		
Acupuncture by a licensed acupuncturist	40%	40%
Acupuncture by a doctor of medicine	40%	50%
Care Outside of Plan Service Area (benefits provided through the 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
Pediatric Vision Benefits – for children up to age 19		
Comprehensive Eye Exam[12]**: one per calendar year** (includes dilation, if professionally indicated)		
Ophthalmologic - Routine ophthalmologic exam with refraction – new patient (S0620) - Routine ophthalmologic exam with refraction – established patient (S0621)	$0[2]	Covered up to a maximum allowance of $30[2]
Optometric - New patient exam (92002/92004) - Established patient exam (92012/92014)	$0[2]	Covered up to a maximum allowance of $30[2]
Eyeglasses		
Lenses: one pair per calendar year - Single vision (V2100-2199) - Conventional (lined) bifocal (V2200-2299) - Conventional (lined) trifocal (V2300-2399) - Lenticular (V2121, V2221, V2321) Lenses include choice of glass or plastic lenses, all lens powers (single vision, bifocal, trifocal, lenticular), fashion and gradient tinting, scratch coating, oversized and glass-grey #3 prescription sunglass lenses. Polycarbonate lenses are covered in full for eligible members.	$0[2]	Covered up to a maximum allowance of: $25 single vision[2] $35 lined bifocal[2] $45 lined trifocal[2] $45 lenticular[2]
Optional Lenses and Treatments		
UV coating (standard only)	$0[2]	Not covered
Anti-reflective coating (standard only)	$35[2]	Not covered
High-index lenses	$30[2]	Not covered
Photochromic lenses (glass or plastic)	$25[2]	Not covered
Polarized lenses	$45[2]	Not covered
Standard progressives	$55[2]	Not covered
Premium progressives	$95[2]	Not covered
Frame (one frame per calendar year) Collection frame Non-collection frame[13] Note: "Collection" frames are available at no cost at participating independent providers. Retail chain providers typically do not display the "Collection," but are required to maintain a comparable selection of frames that are covered in full.	$0[2] Covered up to a maximum allowance of $150[2]	Covered up to a maximum allowance $40[2]
Contact Lenses[14]		
Elective – standard hard (V2500, V2510)	$0[2] (1 pair per year)	Covered up to a maximum allowance of $75[2]
Elective – standard soft (V2520)	$0[2] (1 pair per month for up to 6 months)	Covered up to a maximum allowance of $75[2]
Elective – non-standard hard (V2501, V2502, V2503, V2511, V2512, V2513, V2599)	$0[2] (1 pair per year)	Covered up to a maximum allowance of $75[2]
Elective – non-standard soft (V2521, V2512, V2523)	$0[2] (1 pair per month for up to 3 months)	Covered up to a maximum allowance of $75[2]
Medically necessary	$0[2] (1 pair per year)	Covered up to a maximum allowance of $225[2]
Other Pediatric Vision Benefits		
Supplemental low-vision testing and equipment[15]	35%[2]	Not covered
Diabetes management referral	$0[2]	Not covered

Please Note: Benefits are subject to modification for subsequently enacted state or federal legislation.

Endnotes for Basic PPO for HSA

1 After the calendar year medical deductible is met, the member is responsible for a copayment or coinsurance from participating providers. Participating providers accept Blue Shield's allowable amounts as full payment for covered services. Non-participating providers can charge more than these amounts. The member is responsible for these charges in addition to the applicable copayment or coinsurance when accessing these providers, which amount can be substantial. Amounts applied to the calendar year deductible accrue towards the applicable out-of-pocket maximum. Charges in excess of the allowable amount do not count toward the calendar year medical deductible or out-of-pocket maximum.

2 The covered services listed below are not subject to, and will not accrue to the calendar year medical deductible.
- Durable medical equipment: breast pump
- Family planning benefits: counseling and consulting; diaphragm fitting procedure; implantable contraceptives; injectable contraceptives; insertion and/or removal of IUD device; IUD; and tubal ligation
- Outpatient prescription drug benefits: contraceptive drugs and devices
- Pediatric vision benefits
- Pregnancy and maternity care benefits: prenatal and preconception physician office visits
- Preventive health services

3 Copayments or coinsurance for covered services apply toward the calendar year out-of-pocket maximum, except copayments or coinsurance for the following: (a) additional or reduced payments for failure to utilize the benefits management program; (b) charges in excess of specified benefit maximums; (c) covered travel expenses for bariatric surgery; and (d) dialysis services from a non-participating provider. Copayments, coinsurance, and charges for services not accruing to the calendar year out-of-pocket maximum continue to be the member's responsibility after the calendar year out-of-pocket maximum is reached.

4 The allowable amount for non-emergency services and supplies received from a non-participating hospital or facility is limited to $500 per day. Members are responsible for the coinsurance and all charges that exceed $500 per day.

5 The allowable amount for non-emergency services and supplies received from an ambulatory surgery center is limited to $300 per day. Members are responsible for the coinsurance and all charges that exceed $300 per day. Participating ambulatory surgery centers may not be available in all areas; however, the member can obtain outpatient surgery services from a hospital or an ambulatory surgery center affiliated with a hospital, with payment according to the hospital services benefit.

6 The allowable amount for non-emergency services and supplies received from a non-participating radiology center is limited to $300 per day. Members are responsible for all charges that exceed $300 per day. The allowable amount for non-emergency services and supplies received from a non-participating hospital is limited to $500 per day. Members are responsible for all charges that exceed $500 per day.

7 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 Evidence of Coverage and Summary of Benefits for details.

8 This plan's prescription drug coverage provides less coverage on average than the standard benefit set by the federal government for Medicare Part D (also called non-creditable coverage). It is important to know that generally you may only enroll in a Medicare Part D plan from October 15th through December 7th of each year. If you do not enroll in a Medicare Part D plan when you are first eligible to join, you may be subject to a late enrollment penalty in addition to your Part D premium when you enroll at a later date. For more information about your current plan's prescription drug coverage, call the Customer Service telephone number on your identification card, Monday through Thursday between 8:00 a.m. and 5:00 p.m. or on Friday between 9:00 a.m. and 5:00 p.m. The hearing impaired may call the TTY number at (888) 239-6482.

9 Contraceptive drugs and devices covered under the outpatient prescription drug benefit do not require a copayment and will not be subject to any calendar year medical deductible; however, if a brand contraceptive drug is requested when a generic drug equivalent is available, the member is responsible for paying the difference between the cost to Blue Shield for the brand contraceptive drug and its generic drug equivalent. If the brand contraceptive drug is medically necessary, it may be covered without a copayment with prior authorization. The difference in cost that the member must pay does not accrue to any calendar year medical deductible or out-of-pocket maximum responsibility.

10 If a member or physician requests a brand drug when a generic drug equivalent is available, and the calendar year medical deductible has been satisfied, the member is responsible for paying the difference between the cost to Blue Shield for the brand drug and its generic drug equivalent, as well as the applicable generic drug copayment. The difference in cost that the member must pay does not accrue to any calendar year medical deductible or out-of-pocket maximum responsibility. Refer to the Evidence of Coverage and Summary of Benefits for details.

11 Blue Shield has contracted with a specialized health care service plan to act as our mental health services administrator (MHSA). The MHSA provides mental health and chemical dependency services, other than inpatient services for medical acute detoxification, through a separate network of MHSA participating providers. Inpatient medical acute detoxification is a medical benefit provided by Blue Shield participating or non-participating (not MHSA) providers.

12 The comprehensive examination benefit and allowance does not include fitting and evaluation fees for contact lenses.

13 This benefit covers Collection frames at no cost at participating independent and retail chain providers. Participating retail chain providers typically do not display the frames as "Collection," but are required to maintain a comparable selection of frames that are covered in full. For non-Collection frames, the allowable amount is up to $150; however, if (a) the participating provider uses wholesale pricing, then the wholesale allowable amount will be up to $99.06, or if (b) the participating provider uses warehouse pricing, then the warehouse allowable amount will be up to $103.64. Participating providers using wholesale pricing are identified in the provider directory. If frames are selected that are more expensive than the allowable amount established for this benefit, the member is responsible for the difference between the allowable amount and the provider's charge.

14 Contact lenses are covered in lieu of eyeglasses once per calendar year. See the Definitions section in the Evidence of Coverage for the definitions of Elective Contact Lenses and Non-Elective (Medically Necessary) Contact Lenses. A report from the provider and prior authorization from the Vision Plan Administrator (VPA) is required.

15 A report from the provider and prior authorization from the Vision Plan Administrator is required.

This plan is pending regulatory approval.