Ultimate PPO

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 PPO plan uses the Exclusive PPO provider network.

	Participating Providers[1]	Non-Participating Providers[1]
Calendar Year Medical Deductible	$0	
Calendar Year Out-of-Pocket Maximum[2] (Copayments for participating providers apply to both participating and non-participating provider calendar year out-of-pocket maximum amounts.)	$4,000 per individual / $8,000 per family	$7,000 per individual / $14,000 per family
Calendar Year Brand Drug 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	$20	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)	$20	50%
Preventive Health Benefits		
Preventive health services (as required by federal and California law)	$0	Not covered
OUTPATIENT SERVICES		
Outpatient surgery in a hospital	10%	50%[3]
Outpatient surgery performed at an ambulatory surgery center	10%	50%[4]
Outpatient services for treatment of illness or injury and necessary supplies	10%	50%[3]
Outpatient diagnostic X-ray and imaging performed in a hospital	$40	50%[3]
Outpatient diagnostic laboratory and pathology performed in a hospital	$20	50%[3]
CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine (prior authorization is required)	10%	50%[5]
HOSPITALIZATION SERVICES		
Inpatient physician services	10%	50%
Inpatient non-emergency facility services (semi-private room and board, services and supplies, including subacute care)	10%	50%[3]
Bariatric surgery (prior authorization is required; medically necessary surgery for weight loss is for morbid obesity only)[6]	10%	Not covered
EMERGENCY HEALTH COVERAGE		
Emergency room services not resulting in admission	$150	$150
Emergency room services resulting in admission (when the member is admitted directly from the ER)	10%	10%
Emergency room physician services	10%	10%
Urgent care	$40	50%
AMBULANCE SERVICES		
Emergency or authorized transport (ground or air)	$150	$150

Covered Services	Member Copayments	
PRESCRIPTION DRUG COVERAGE[7,8,9]	**Participating Pharmacy**	**Non-Participating Pharmacy**
Retail Prescriptions (up to a 30-day supply)		
Contraceptive drugs and devices[8]	$0	Not covered
Generic drugs	$5 per prescription	Not covered
Preferred brand drugs	$15 per prescription	Not covered
Non-preferred brand drugs	$25 per prescription	Not covered
Mail Service Prescriptions (up to a 90-day supply)		
Contraceptive drugs and devices[8]	$0	Not covered
Generic drugs	$15 per prescription	Not covered
Preferred brand drugs	$45 per prescription	Not covered
Non-preferred brand drugs	$75 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.)	10%	Not covered
	Participating Providers[1]	**Non-Participating Providers**[1]
PROSTHETICS/ORTHOTICS		
Prosthetic equipment and devices (separate office visit copay may apply)	10%	50%
Orthotic equipment and devices (separate office visit copay may apply)	10%	50%
DURABLE MEDICAL EQUIPMENT		
Breast pump	$0	Not covered
Other durable medical equipment	10%	50%
MENTAL HEALTH SERVICES[10]		
Inpatient hospital services (prior authorization required)	10%	50%[3]
Outpatient mental health services (some services may require prior authorization and facility charges)	$20	50%
SUBSTANCE ABUSE SERVICES[10]		
Inpatient hospital services for medical acute detoxification (prior authorization required)	10%	50%[3]
Outpatient substance abuse services (some services may require prior authorization and facility charges)	$20	50%
HOME HEALTH SERVICES		
Home health care agency services (up to 100 prior authorized visits per calendar year)	10%	Not covered (unless prior authorized)
OTHER		
Pregnancy and Maternity Care Benefits		
Prenatal physician office visits	$0	50%
Postnatal physician office visits	$20	50%
Inpatient hospital services for normal delivery and cesarean section	10%	50%[3]
Family Planning Benefits		
Injectable and implantable contraceptives	$0	Not covered
Counseling and consulting	$0	Not covered
Tubal ligation	$0	Not covered
Vasectomy	10%	Not covered
Elective abortion	10%	Not covered
Infertility services	Not covered	Not covered
Rehabilitation and Habilitation Benefits		
Office location	$20	50%
Outpatient department of a hospital	$20	50%[3]
Chiropractic Benefits		
Chiropractic services	Not covered	Not covered
Acupuncture Benefits		
Acupuncture by a licensed acupuncturist	$20	$20
Acupuncture by a doctor of medicine	$20	50%

Covered Services	Member Copayments	
	Participating Providers[1]	**Non-Participating Providers**[1]
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[11]: 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	Covered up to a maximum allowance of $30
Optometric - New patient exam (92002/92004) - Established patient exam (92012/92014)	$0	Covered up to a maximum allowance of $30
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	Covered up to a maximum allowance of: $25 single vision $35 lined bifocal $45 lined trifocal $45 lenticular
Optional Lenses and Treatments		
UV coating (standard only)	$0	Not covered
Anti-reflective coating (standard only)	$35	Not covered
High-index lenses	$30	Not covered
Photochromic lenses (glass or plastic)	$25	Not covered
Polarized lenses	$45	Not covered
Standard progressives	$55	Not covered
Premium progressives	$95	Not covered
Frame (one frame per calendar year) Collection frame Non-collection frame[12] 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 Covered up to a maximum allowance of $150	Covered up to a maximum allowance $40
Contact Lenses[13]		
Elective – standard hard (V2500, V2510)	$0 (1 pair per year)	Covered up to a maximum allowance of $75
Elective – standard soft (V2520)	$0 (1 pair per month for up to 6 months)	Covered up to a maximum allowance of $75
Elective – non-standard hard (V2501, V2502, V2503, V2511, V2512, V2513, V2599)	$0 (1 pair per year)	Covered up to a maximum allowance of $75
Elective – non-standard soft (V2521, V2512, V2523)	$0 (1 pair per month for up to 3 months)	Covered up to a maximum allowance of $75
Medically necessary	$0 (1 pair per year)	Covered up to a maximum allowance of $225 for medically necessary contact lenses
Other Pediatric Vision Benefits		
Supplemental low-vision testing and equipment[14]	35%	Not covered
Diabetes management referral	$0	Not covered

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

Endnotes for Ultimate PPO

1 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 which the member is responsible for in addition to the applicable copayment or coinsurance when accessing these providers, which amount can be substantial. Charges in excess of the allowable amount do not count toward the calendar year out-of-pocket maximum.

2 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.

3 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.

4 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.

5 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.

6 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.

7 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 Medicare Part D premium.

8 Contraceptive drugs and devices covered under the outpatient prescription drug benefit do not require a copayment; 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 out-of-pocket maximum responsibility.

9 If a member or physician requests a brand drug when a generic drug equivalent is available, 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 out-of-pocket maximum responsibility. Refer to the Evidence of Coverage and Summary of Benefits for details.

10 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.

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

12 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.

13 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.

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

This plan is pending regulatory approval.