# Blue Shield Silver 94 HMO

This federally subsidized plan is only available to those whose income is 100-150% above federal poverty level.

**Uniform Health Plan Benefits and Coverage Matrix**

## Blue Shield of California

Effective January 1, 2017

**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 plan is available only in certain California counties and cities "Service Area" as described in the *Evidence of Coverage*. You must reside in this select Service Area in order to enroll in this plan.
This health plan utilizes an Accountable Care Organization (ACO) for its provider network. Except for Emergency Services, Urgent Services when the Member is out of the Service Area, or when prior authorized, all services must be obtained through the Member's Personal Physician and within the Trio ACO HMO Provider Network to be covered.

**This health plan uses the Trio ACO HMO Provider Network.**

| | **Plan Providers [1]** |
|---|---|
| **Calendar Year Medical Deductible [1]** | $75 per individual / $150 per family |
| **Calendar Year Out-of-Pocket Maximum [2]**<br>(Any calendar year medical deductible accrues to the calendar year out-of-pocket maximum.) | $2,350 per individual / $4,700 per family |
| **Lifetime Benefit Maximum** | None |

| **Covered Services** | **Member Copayment** |
|---|---|
| | **Plan Providers [1]** |
| **PROFESSIONAL SERVICES** | |
| **Professional Benefits** | |
| Primary care physician office visit<br>(Note: A woman may self-refer to an OB/GYN or family practice physician in her personal physician's medical group or IPA for OB/GYN services) | $5 per visit |
| Other practitioner office visit | $5 per visit |
| Specialist physician office visit<br>(see also the **Access+ *Specialist*$^{SM}$ Benefit** below) | $8 per visit |
| Teladoc consultation | $5 per consultation |
| **Allergy Testing and Treatment Benefits** | |
| Primary care physician office visits<br>(includes visits for allergy serum injections) | $5 per visit |
| Specialist physician office visits<br>(includes visits for allergy serum injections) | $8 per visit |
| Allergy serum purchased separately for treatment | 10% |
| **Access+ *Specialist*$^{SM}$ Benefits [3]** | |
| Office visit, examination or other consultation<br>(self-referred office visits and consultations only) | $8 per visit |
| **Preventive Health Benefits** | |
| Preventive health services<br>(as required by applicable Federal and California law) | $0 |
| **OUTPATIENT SERVICES** | |
| **Hospital Benefits (Facility Services)** | |
| Outpatient surgery performed at a free-standing ambulatory surgery center [4] | 10% |
| Outpatient surgery performed in a hospital or a hospital affiliated ambulatory surgery center [4] | 10% |
| Outpatient visit | 10% |
| | **Plan Providers [1]** |

| Covered Services | Member Copayment |
|---|---|
| Outpatient services for treatment of illness or injury and necessary supplies<br>(except as described under "Rehabilitation Benefits" and "Speech Therapy Benefits") | 10% |
| CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine performed in a hospital<br>(prior authorization required) | $50 per visit |
| Outpatient diagnostic x-ray and imaging performed in a hospital | $8 per visit |
| Outpatient diagnostic laboratory and pathology performed in a hospital | $8 per visit |
| **HOSPITALIZATION SERVICES** | |
| **Hospital Benefits (Facility Services)** | |
| Inpatient physician fee | 10%<br>(Subject to the calendar year medical deductible) |
| Inpatient non-emergency facility fee<br>(semi-private room and board, and medically necessary services and supplies, including sub-acute care) | 10%<br>(Subject to the calendar year medical deductible) |
| **INPATIENT SKILLED NURSING BENEFITS** [5]<br>(combined maximum of up to 100 days per benefit period; prior authorization required; semi-private accommodations) | |
| Services by a free-standing skilled nursing facility | 10%<br>(Subject to the calendar year medical deductible) |
| Skilled nursing unit of a hospital | 10%<br>(Subject to the calendar year medical deductible) |
| **EMERGENCY HEALTH COVERAGE** | |
| Emergency room visit not resulting in admission - facility fee<br>(copayment does not apply if the Member is directly admitted to the hospital for inpatient services) | $50 per visit |
| Emergency room visit resulting in admission – facility fee<br>(when the Member is admitted directly from the Emergency Room) | 10%<br>(Subject to the calendar year medical deductible) |
| Emergency room visit not resulting in admission - physician fee<br>(copayment does not apply if the Member is directly admitted to the hospital for inpatient services) | $0 |
| Emergency room visit resulting in admission - physician fee | $0 |
| **AMBULANCE SERVICES** | |
| Emergency or authorized transport<br>(ground or air) | $30<br>(Subject to the calendar year medical deductible) |
| **PRESCRIPTION DRUG (PHARMACY) COVERAGE** [6, 7, 8, 9, 10, 11, 12] | **Plan Pharmacy** |
| **Retail Pharmacies** (up to a 30-day supply) | |
| Contraceptive drugs and devices [7] | $0 |
| Tier 1 Drugs | $3 per prescription |
| Tier 2 Drugs | $10 per prescription |
| Tier 3 Drugs | $15 per prescription |
| Tier 4 Drugs (excluding Specialty Drugs) | 10% up to $150 maximum per prescription |
| **Mail Service Pharmacies** (up to a 90-day supply) | |
| Contraceptive drugs and devices [7] | $0 |
| Tier 1 Drugs | $9 per prescription |
| Tier 2 Drugs | $30 per prescription |
| Tier 3 Drugs | $45 per prescription |
| Tier 4 Drugs (excluding Specialty Drugs) | 10% up to $450 maximum per prescription |
| **Network Specialty Pharmacies** [9, 10, 11] (up to a 30-day supply) | |
| Tier 4 Drugs | 10% up to $150 maximum per prescription |
| Oral anticancer medications | 10% up to $200 maximum per prescription |
| | **Plan Providers** [1] |
| **PROSTHETICS/ORTHOTICS** | |
| Prosthetic equipment and devices<br>(separate office visit copayment may apply) | 10% |
| Orthotic equipment and devices<br>(separate office visit copayment may apply) | 10% |

| Covered Services | Member Copayment<br>Plan Providers [1] |
|---|---|
| **DURABLE MEDICAL EQUIPMENT** | |
| Breast pump | $0 |
| Other durable medical equipment<br>(Member share is based upon allowed charges) | 10% |
| **MENTAL HEALTH AND BEHAVIORAL HEALTH SERVICES** [13] | |
| Inpatient hospital services<br>(prior authorization required) | 10%<br>(Subject to the calendar year medical deductible) |
| Residential care<br>(prior authorization required) | 10%<br>(Subject to the calendar year medical deductible) |
| Inpatient professional (physician) services<br>(prior authorization required) | 10%<br>(Subject to the calendar year medical deductible) |
| Routine outpatient mental health and behavioral health services<br>(includes professional/physician visits; some services may require prior authorization and facility charges) | $5 per visit |
| Non-routine outpatient mental health and behavioral health services<br>(includes behavioral health treatment, electroconvulsive therapy, intensive outpatient programs, psychological testing, partial hospitalization programs, and transcranial magnetic stimulation. Some services may require prior authorization and facility charges. Higher copayment and facility charges per episode of care may apply for partial hospitalization programs.) | $0 |
| **SUBSTANCE USE DISORDER SERVICES** [13] | |
| Inpatient hospital services<br>(prior authorization required) | 10%<br>(Subject to the calendar year medical deductible) |
| Residential care<br>(prior authorization required) | 10%<br>(Subject to the calendar year medical deductible) |
| Inpatient professional (physician) services<br>(prior authorization required) | 10%<br>(Subject to the calendar year medical deductible) |
| Routine outpatient substance use disorder services<br>(includes professional/physician visits; some services may require prior authorization and facility charges) | $5 per visit |
| Non-routine outpatient substance use disorder services<br>(includes intensive outpatient programs, partial hospitalization programs, and office-based opioid detoxification and/or maintenance therapy. Some services may require prior authorization and facility charges. Higher copayment and facility charges per episode of care may apply for partial hospitalization programs.) | $0 |
| **HOME HEALTH SERVICES** | |
| Home health care agency visits<br>(up to 100 prior authorized visits per calendar year) | $3 per visit |
| Home infusion/home intravenous injectable therapy | $0 |
| Home infusion nursing visits provided by a home infusion agency | $3 per visit |
| **HOSPICE PROGRAM BENEFITS** | |
| Routine home care | $0 |
| Inpatient respite care | $0 |
| 24-hour continuous home care | $0 |
| Short-term inpatient care for pain and symptom management | $0 |
| **CHIROPRACTIC BENEFITS** | |
| Chiropractic services | Not Covered |
| **ACUPUNCTURE BENEFITS** | |
| Acupuncture services<br>(benefits provided are for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain only) | $5 per visit |
| **REHABILITATION AND HABILITATIVE BENEFITS**(Physical, Occupational, and Respiratory Therapy) | |
| Office location | $5 per visit |
| **SPEECH THERAPY BENEFITS** | |
| Office location | $5 per visit |
| **PREGNANCY AND MATERNITY CARE BENEFITS** | |
| Prenatal and preconception physician office visit<br>(for inpatient hospital services, see "Hospitalization Services") | $0 |
| Delivery and all inpatient physician services | 10%<br>(Subject to the calendar year medical deductible) |
| Postnatal physician office visit: initial visit<br>(for inpatient hospital services, see "Hospitalization Services") | No Charge |
| Abortion services<br>(an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center) | 10% |

| Covered Services | Member Copayment<br>Plan Providers [1] |
|---|---|
| **FAMILY PLANNING BENEFITS** | |
| Counseling, consulting, and education<br>(includes insertion of IUD, as well as injectable and implantable contraceptives for women) | $0 |
| Tubal ligation | $0 |
| Vasectomy<br>(an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center) | 10% |
| Infertility services | Not Covered |
| **DIABETES CARE BENEFITS** | |
| Devices, equipment, and non-testing supplies<br>(Member share is based upon allowed charges; for testing supplies see "Prescription Drug Coverage") | 10% |
| Diabetes self-management training in an office setting | $0 |
| **URGENT CARE BENEFITS**<br>(BlueCard® Program) | |
| Urgent services outside your personal physician service area | $5 per visit |
| **PEDIATRIC VISION BENEFITS** [14] – Pediatric vision benefits are available for Members through the end of the month in which the Member turns 19. All pediatric vision benefits are provided through MESVision, Blue Shield's Vision Plan Administrator. | |
| **Comprehensive Eye Exam** [15] **one per calendar year**<br>(includes dilation, if professionally indicated) | |
| Ophthalmologic<br>- Routine ophthalmologic exam with refraction – new patient (S0620)<br>- Routine ophthalmologic exam with refraction – established patient (S0621) | $0 |
| Optometric<br>- New patient exam (92002/92004)<br>- Established patient exam (92012/92014) | $0 |
| Eyeglasses | |
| Lenses: one pair per calendar year<br>- Single vision (V2100-2199)<br>- Conventional (lined) bifocal (V2200-2299)<br>- Conventional (lined) trifocal (V2300-2399)<br>- Lenticular (V2121, V2221, V2321)<br>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. | $0 |
| Optional Lenses and Treatments | |
| UV coating (standard only) | $0 |
| Polycarbonate lenses | $0 |
| Anti-reflective coating (standard only) | $35 |
| High-index lenses | $30 |
| Photochromic lenses – plastic | $0 |
| Photochromic lenses – glass | $25 |
| Polarized lenses | $45 |
| Standard progressives | $0 |
| Premium progressives | $95 |
| Frame [16] (one frame per calendar year) | |
| Collection frame<br>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 |
| Non-collection frame (V2020) | Covered up to $150 maximum Allowance |
| Contact Lenses [17] | |
| Elective (Cosmetic/Convenience) – standard hard (V2500, V2510) | $0 |
| Elective (Cosmetic/Convenience) – standard soft (V2520)<br>(One pair per month, up to 6 months, per Calendar Year) | $0 |
| Elective (Cosmetic/Convenience) – non-standard hard (V2501-V2503, V2511-V2513, V2530-V2531) | $0 |
| Elective (Cosmetic/Convenience) – non-standard soft (V2521-V2523)<br>(One pair per month, up to 3 months, per Calendar Year) | $0 |
| Non-Elective (Medically Necessary) – hard or soft [18] | $0 |
| Other Pediatric Vision Benefits | |
| Comprehensive low vision exam [18]<br>(Once every 5 Calendar Years) | $0 |
| Low vision devices [18]<br>(One aid per Calendar Year) | $0 |
| Diabetes management referral | $0 |

| Covered Services | Member Copayment<br>Plan Providers [1] |
|---|---|
| **PEDIATRIC DENTAL BENEFITS** [19] – Pediatric dental benefits are available for Members through the end of the month in which the Member turns 19. All pediatric dental benefits are provided by Dental Benefits Providers, Blue Shield's Dental Plan Administrator. | |
| Diagnostic and Preventive | |
| Oral exam | $0 |
| Preventive – cleaning | $0 |
| Preventive – x-ray | $0 |
| Sealants per tooth | $0 |
| Topical fluoride application | $0 |
| Space maintainers – fixed | $0 |
| Basic Services [20] | |
| Restorative procedures | 20% |
| Periodontal maintenance services | 20% |
| Major Services [20] | |
| Crowns and casts | 50% |
| Endodontics | 50% |
| Periodontics (other than maintenance) | 50% |
| Prosthodontics | 50% |
| Oral surgery | 50% |
| Orthodontics [20, 21] | |
| Medically necessary orthodontics | 50% |

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

### Endnotes

1. For family coverage, there is an individual medical deductible within the family medical deductible. This means that the medical deductible will be met for an individual who meets the individual medical deductible prior to meeting the family medical deductible.

   After the calendar year medical deductible is met, the Member is responsible for a copayment or coinsurance from plan providers.

2. For family coverage, there is also an individual out-of-pocket maximum within the family out-of-pocket maximum. This means that the out-of-pocket maximum will be met for an individual who meets the individual out-of-pocket maximum prior to the family meeting the family out-of-pocket maximum.

   Copayments or coinsurance for covered services accrue to the calendar year out-of-pocket maximum, except copayments or coinsurance for:
   • Charges in excess of specified benefit maximums

   Copayments and charges for services not accruing to the Member's calendar year out-of-pocket maximum continue to be the Member's responsibility after the calendar year out-of-pocket maximum is reached. Please refer to the Summary of Benefits and *Evidence of Coverage* for additional details.

3. To use this option, Members must select a personal physician who is affiliated with a medical group or IPA that is an Access+ provider group, which offers the Access+ Specialist feature. Members should then select a specialist within that medical group or IPA. Access+ Specialist visits for mental health or substance use disorder services must be provided by a MHSA network participating provider.

4. Participating ambulatory surgery centers may not be available in all areas. Outpatient surgery services may also be obtained from a hospital or an ambulatory surgery center that is affiliated with a hospital, and paid according to the hospital services benefits.

5. Skilled nursing services are limited to 100 preauthorized days during a benefit period except when received through a hospice program provided by a participating hospice agency. This 100 preauthorized day maximum on skilled nursing services is a combined maximum between SNF in a hospital unit and skilled nursing facilities.

6. 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.

7. Contraceptive drugs and devices covered under the outpatient prescription drug benefit do not require a copayment and are not subject to the calendar year medical deductible. However, if a brand contraceptive drug is selected when a Tier 1 drug equivalent is available, the Member is responsible for paying the difference between the cost to Blue Shield for the brand contraceptive and its Tier 1 drug equivalent. The difference in cost that the Member must pay does not accrue to any calendar year medical or pharmacy deductible and is not included in the calendar year out-of-pocket maximum responsibility calculation. The Member or physician may request a medical necessity exception to the difference in cost as further described in the *Evidence of Coverage*. In addition, select brand contraceptives may need prior authorization to be covered without a copayment.

8. If the Member or physician selects a brand drug when a Tier 1 drug equivalent is available, the Member is responsible for paying the difference in cost between the cost to Blue Shield for the brand drug and its Tier 1 drug equivalent, in addition to the Tier 1 copayment. The difference in cost that the Member must pay does not accrue to any

calendar year out-of-pocket maximum responsibility calculation. The Member or physician may request a medical necessity exception to the difference in cost as further described in the *Evidence of Coverage*. Refer to the *Evidence of Coverage* and Summary of Benefits for details.

9. 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 which may also require 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.

10. 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.

11. Blue Shield's Short-Cycle Specialty Drug Program allows initial prescriptions for select Specialty Drugs to be dispensed for a 15-day trial supply, as further described in the *Evidence of Coverage*. In such circumstances, the applicable Specialty Drug copayment or coinsurance will be pro-rated.

12. Drugs obtained at a non-participating pharmacy are not covered, unless medically necessary for a covered emergency, including drugs for emergency contraception.

13. Mental Health and Substance Use Disorder Services are accessed through Blue Shield's Mental Health Service Administrator (MHSA) using Blue Shield's MHSA participating providers. Services for acute medical detoxification are accessed through Blue Shield using Blue Shield's participating providers.

14. All vision services must be provided through a participating vision care provider. For a list of participating vision providers, Members can search in the "Find a Provider" section of blueshieldca.com. All pediatric vision benefits are provided through MESVision, Blue Shield's Vision Plan Administrator. Any vision services deductibles, copayments, and coinsurance for covered vision services from participating vision providers accrue to the calendar year out-of-pocket maximum. Costs for non-covered services, services from non-participating vision providers, charges in excess of benefit maximums, and premiums, do not accrue to the calendar year out-of-pocket maximum.

15. The comprehensive examination benefit allowance includes fitting, evaluation and follow-up care fees for Non-Elective (Medically Necessary) Contact Lenses (hard or soft) or Elective Contact Lenses (standard hard or soft) in lieu of eyeglasses by Participating or Preferred Providers.

16. 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.

17. Contact lenses are covered in lieu of eyeglasses. 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.

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

19. Pediatric dental benefits are available through a network of participating dentists. With the exception of emergency dental services, all dental services must be provided through a participating dentist in this network. For a list of participating dentists, Members can search in the "Find a Provider" section of blueshieldca.com. All pediatric dental benefits are provided by Dental Benefits Providers, Blue Shield's Dental Plan Administrator.

    Copayments and coinsurance for covered dental services accrue to the calendar year out-of-pocket maximum, including any copayments for covered orthodontia services received. Costs for non-covered services, charges in excess of benefit maximums, and premiums, do not accrue to the calendar year out-of-pocket maximum.

20. There are no waiting periods for pediatric dental services.

21. The Member's Copayment or Coinsurance for covered Medically Necessary Orthodontia services applies to a course of treatment even if it extends beyond a Calendar Year. This applies as long as the Member remains enrolled in the Plan.

*Benefit plans may be modified to ensure compliance with state and federal requirements.*

*Pending Regulatory Approval*