Vital Shield Plus 900 Generic Rx

Underwritten by Blue Shield of California Life & Health Insurance Company. Pending regulatory approval.

Uniform Health Plan Benefits and Coverage Matrix

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

	Preferred Providers[1]	Non-preferred Providers[1]
Calendar Year Medical Deductible[2]	$900 per individual / $1,800 per family	$5,000 per individual / $10,000 per family (excludes Preferred Provider deductible)
Calendar Year Copayment Maximum (Includes the medical plan deductible)	$3,900 per individual / $7,800 per family	$15,000 per individual / $30,000 per family (excludes Preferred Provider Copayment Maximum)
Lifetime Benefit Maximum	None	

Covered Services	Member Copayments	
	Preferred Providers[1]	Non-preferred Providers[1]
PROFESSIONAL SERVICES		
Professional (Physician) Benefits		
Physician and specialist office visits (First four visits per Calendar Year are covered prior to meeting the Copayment Maximum – subsequent visits are subject to the Copayment Maximum)	$30[3,4,5]	$0 after copay maximum[5]
Subsequent physician and specialist office visits	$0 after copay maximum[3,5]	$0 after copay maximum[5]
Other outpatient X-ray, pathology, and laboratory (Diagnostic testing by providers other than outpatient laboratory, pathology, and imaging departments of hospitals/facilities)	$0 after copay maximum[6]	$0 after copay maximum[5]
CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine (prior authorization is required)	$0 after copay maximum[6]	$0 after copay maximum[5]
Preventive Health Benefits		
Preventive Health Services (see the description of Preventive Health Services in the definitions section of the *Policy* for more information)	$0[4]	Not covered
OUTPATIENT SERVICES		
Outpatient surgery in a hospital	40%	50%[7,8]
Outpatient surgery performed at an Ambulatory Surgery Center	40%	50%[7,9]
Outpatient Services for treatment of illness or injury and necessary supplies (Except as described under "Rehabilitation benefits")	40%	50%[8]
Other outpatient X-ray, pathology and laboratory performed in a hospital	$0 after copay maximum[6]	$0 after copay maximum[5]
Bariatric Surgery (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only)[10]	40%	50%[7,8]
CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine performed in a hospital (prior authorization is required)	$0 after copay maximum[5]	$0 after copay maximum[5]
HOSPITALIZATION SERVICES		
Inpatient Physician Services	40%	50%
Inpatient Non-emergency Facility Services (Semi-private room and board, and medically-necessary Services and supplies, including Subacute Care)	40%	50%[7,8]
Bariatric Surgery (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only)[10]	40%	50%[7,8]
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 visit + 40%	$100 per visit + 40%
Emergency room Services resulting in admission (when the member is admitted directly from the ER)	40%	40%
Emergency room Physician Services	40%	40%

Covered Services	Member Copayments	
	Preferred Providers[1]	**Non-preferred Providers**[1]
AMBULANCE SERVICES		
Emergency or authorized transport (surface or air)	40%	40%
PRESCRIPTION DRUG COVERAGE[11,12]	**Participating Pharmacy**	
Retail prescriptions (up to a 30-day supply)		
Formulary Generic Drugs	$10 per prescription[4,13]	
Formulary Brand Name Drugs	Not covered	
Non-Formulary Brand Name Drugs	Not covered	
Mail Service Prescriptions (up to a 60-day supply)		
Formulary Generic Drugs	$20 per prescription[4,13]	
Formulary Brand Name Drugs	Not covered	
Non-Formulary Brand Name Drugs	Not covered	
Specialty Pharmacies (up to a 30-day supply)		
Home Self-Administered Injectables	40%[13]	
	Preferred providers[1]	**Non-preferred Providers**[1]
PROSTHETICS/ORTHOTICS		
Prosthetic equipment and devices (Separate office visit copay may apply)	Not covered	Not covered
Orthotic equipment and devices (Separate office visit copay may apply)	Not covered	Not covered
DURABLE MEDICAL EQUIPMENT		
Durable Medical Equipment	Not covered	Not covered
MENTAL HEALTH SERVICES (PSYCHIATRIC)[14]		
Inpatient Hospital Services	40%	50%[7,8]
Outpatient visits for severe mental health conditions	40%	50%[7,8]
Outpatient visits for non-severe mental health conditions[15]	Not covered	Not covered
CHEMICAL DEPENDENCY SERVICES[14] **(SUBSTANCE ABUSE)**		
Inpatient Hospital Services for medical acute detoxification	40%	50%[7,8]
Outpatient visits[15]	Not covered	Not covered
HOME HEALTH SERVICES		
Home health care agency Services (up to 90 prior authorized visits per Calendar Year)	$0 after copay maximum[5]	Not covered
OTHER		
Pregnancy and Maternity Care Benefits		
Prenatal and postnatal Physician office visits	Not covered	Not covered
All necessary Inpatient Hospital Services for normal delivery and Cesarean section	Not covered	Not covered
Family Planning Benefits		
Counseling and consulting	$0 after copay maximum[5]	Not covered
Tubal ligation	$0 after copay maximum[5]	Not covered
Vasectomy	$0 after copay maximum[5]	Not covered
Elective abortion	$0 after copay maximum[5]	Not covered
Rehabilitation Benefits		
Office location	Not covered	Not covered
Chiropractic Benefits		
Chiropractic Services	Not covered	Not covered
Acupuncture Benefits		
Acupuncture	Not covered	Not covered
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

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

1 Member is responsible for copayment or coinsurance in addition to any charges above allowable amounts. The coinsurance indicated is a percentage of the allowable amounts. Preferred providers accept the Plan's allowable amounts as payment-in-full for covered services. Non-preferred providers can charge more than these amounts. When members use non-preferred providers, they must pay the applicable copayment or coinsurance plus any charges that exceed the Plan's allowable amount. Charges above the allowable amount do not count toward the plan deductible or copayment/coinsurance maximum.

2 If the annual plan deductible has not been met, any charges that accumulate towards the plan deductible in the last three months of the calendar year will be credited towards the plan deductible for the following calendar year.

3 Member has four visits per calendar year before the calendar year copayment/coinsurance maximum is met. After the four visits are used, the member pays 100% of the allowable amount until the calendar year copayment/coinsurance maximum is met, with no accrual to deductible or copayment/coinsurance maximum. Subsequent visits are $0 after the copayment/coinsurance maximum is reached.

4 Benefit is available prior to meeting any deductible.

5 These copayments do not count toward the medical deductible or copayment/coinsurance maximum, but will not be charged once the copayment/coinsurance maximum is reached. See Policy for details.

6 These copayments do not count toward the medical deductible, but do count toward the copayment/coinsurance maximum, and will not be charged once the copayment/coinsurance maximum is reached. See Policy for details.

7 These copayments do not count toward the copayment/coinsurance maximum. They will continue to be charged once the copayment/coinsurance maximum is reached. See Policy for details.

8 For non-emergency hospital services and supplies received from a non-preferred hospital, Blue Shield's payment is limited to $250 per day. Members are responsible for all charges that exceed $250 per day.

9 Participating ambulatory surgery centers may not be available in all areas. Regardless of their availability, you can obtain outpatient surgery services from a hospital, or an ambulatory surgery center affiliated with a hospital with payment according to your health plan's hospital services benefits. Blue Shield's payment is limited to $150 per day. Members are responsible for all charges that exceed $150 per day.

10 Bariatric surgery is covered when pre-authorized by the Plan. 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 preferred provider and there is no coverage for bariatric services from non-preferred providers. In addition, if prior authorized by the Plan, 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 Policy for further benefit details.

11 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.

12 Brand-name prescription drugs are not covered with the exception of covered drugs and supplies for diabetes**.** Brand and generic diabetes medications/supplies are covered, and may be subject to Prior Authorization for medical necessity. See Policy for details.

13 These copayments do not count toward the medical deductible or copayment/coinsurance maximum. They will continue to be charged once the copayment/coinsurance maximum is reached. See Policy for details.

14 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 preferred or non-preferred (not MHSA) providers.

15 For MHSA participating providers, the initial visit is treated as if the condition was a severe mental illness or serious emotional disturbance of a child. For MHSA non-participating providers, the initial visit is treated as if it were an MHSA participating provider.