Blue Shield Silver 70 HMO 1500/45 Network 1 Mirror w/ Child Dental

Benefit Summary (For groups 1 to 100)
(Uniform Health Plan Benefits and Coverage Matrix)

Blue Shield of California

Effective January 1, 2016

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE *EVIDENCE OF COVERAGE* AND PLAN CONTRACT 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 Benefit Summary Guide and the *Evidence of Coverage*. You must live and/or work in this select Service Area in order to enroll in this plan. With the exception of emergency services, you must use providers from the provider network for this health plan, which is the Local Access+ HMO Provider Network.

This health plan uses the Local Access+ HMO Provider Network

Calendar Year Medical Deductible[1]	$1,500 per individual / $3,000 per family
Calendar Year Out-of-Pocket Maximum[1] (Any calendar year medical deductible and any calendar year pharmacy deductible accrues to the calendar year out-of-pocket maximum.)	$6,500 per individual / $13,000 per family
Calendar Year Pharmacy Deductible (Does not apply to contraceptive drugs and devices. Otherwise applicable to covered drugs in Tiers 2, 3, and 4. Separate from the calendar year medical deductible. Accrues to the calendar year out-of-pocket maximum.)	$250 per individual / $500 per family
LIFETIME BENEFIT MAXIMUM	None
Covered Services	**Member Copayment**
PROFESSIONAL SERVICES	
Professional Benefits	
Primary care physician office visits (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)	$45 per visit
Other practitioner office visit	$45 per visit
Specialist physician office visit (also see the **Access+ *Specialist*[SM] Benefit** below)	$70 per visit
Allergy Testing and Treatment Benefits	
Primary care physician office visits (includes visits for allergy serum injections)	$45 per visit
Specialist physician office visits (includes visits for allergy serum injections)	$70 per visit
Allergy serum purchased separately for treatment	20%
Access+ *Specialist*[SM] Benefits[2]	
Office visit, examination or other consultation (self-referred office visits and consultations only)	$70 per visit
Preventive Health Benefits	
Preventive health services (as required by applicable Federal and California law)	No Charge
OUTPATIENT SERVICES	
Hospital Benefits (Facility Services)	
Outpatient surgery performed at a free-standing ambulatory surgery center[3]	20%
Outpatient surgery performed in a hospital or a hospital affiliated ambulatory surgery center[3]	20%
Outpatient visit	20%
Outpatient services for treatment of illness or injury and necessary supplies (except as described under "Rehabilitation Benefits" and "Speech Therapy Benefits")	20%

OUTPATIENT X-RAY, IMAGING, PATHOLOGY AND LABORATORY BENEFITS	
CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine performed in a hospital or free-standing radiological center (prior authorization is required)	$250 per visit
Outpatient diagnostic x-ray and imaging (non-hospital based or affiliated)	$65 per visit
Outpatient diagnostic laboratory and pathology (non-hospital based or affiliated)	$35 per visit
HOSPITALIZATION SERVICES	
Hospital Benefits (Facility Services)	
Inpatient physician services	20% (subject to the calendar year medical deductible)
Inpatient non-emergency facility services (semi-private room and board, and medically-necessary services and supplies, including subacute care)	20% (subject to the calendar year medical deductible)
INPATIENT SKILLED NURSING BENEFITS[5] (combined maximum of up to 100 days per benefit period; prior authorization is required; semi-private accommodations)	
Services by a free-standing skilled nursing facility	20% (subject to the calendar year medical deductible)
Skilled nursing unit of a hospital	20% (subject to the calendar year medical deductible)
EMERGENCY HEALTH COVERAGE	
Emergency room visit not resulting in admission – facility fee (copayment does not apply if the member is directly admitted to the hospital for inpatient services)	$250 per visit (subject to the calendar year medical deductible)
Emergency room visit resulting in admission – facility fee (when the member is admitted directly from the ER)	20% (subject to the calendar year medical deductible)
Emergency room physician visit not resulting in admission – physician fee (copayment does not apply if the member is directly admitted to the hospital for inpatient services)	$50 per visit (subject to the calendar year medical deductible)
Emergency room physician visit resulting in admission – physician fee	20% (subject to the calendar year medical deductible)
AMBULANCE SERVICES	
Emergency or authorized transport (ground or air)	$250 (subject to the calendar year medical deductible)
PRESCRIPTION DRUG (PHARMACY) COVERAGE[4,6,7,9,10,11,12]	
Retail Pharmacies (up to a 30-day supply)	
Contraceptive drugs and devices[7]	No Charge
Tier 1 Drugs	$15 per prescription
Tier 2 Drugs	$55 per prescription (subject to the calendar year pharmacy deductible)
Tier 3 Drugs	$75 per prescription (subject to the calendar year pharmacy deductible)
Tier 4 Drugs (excluding Specialty Drugs)	20% up to $250 maximum per prescription (subject to the calendar year pharmacy deductible)
Mail Service Pharmacies (up to a 90-day supply)	
Contraceptive drugs and devices[7]	No Charge
Tier 1 Drugs	$30 per prescription
Tier 2 Drugs	$110 per prescription (subject to the calendar year pharmacy deductible)
Tier 3 Drugs	$150 per prescription (subject to the calendar year pharmacy deductible)

Tier 4 Drugs (excluding Specialty Drugs)	20% up to $500 maximum per prescription (subject to the calendar year pharmacy deductible)
Network Specialty Pharmacies[6] (up to a 30-day supply)	
Tier 4 Drugs	20% up to $250 maximum per prescription (subject to the calendar year pharmacy deductible)
Oral anticancer medications	20% up to $200 maximum per prescription (subject to the calendar year pharmacy deductible)
PROSTHETICS/ORTHOTICS	
Prosthetic equipment and devices (separate office visit copayment may apply)	No Charge
Orthotic equipment and devices (separate office visit copayment may apply)	No Charge
DURABLE MEDICAL EQUIPMENT	
Breast pump	No Charge
Other durable medical equipment (member share is based upon allowed charges)	20%
MENTAL HEALTH AND BEHAVIORAL HEALTH SERVICES [8]	
Inpatient hospital services (prior authorization required)	20% (subject to the calendar year medical deductible)
Residential care (prior authorization is required)	20% (subject to the calendar year medical deductible)
Inpatient professional (physician) services (prior authorization required)	20% (subject to the calendar year medical deductible)
Routine outpatient mental health and behavioral health services (includes professional/physician visits; some services may require prior authorization and facility charges)	$45 per visit
Non-routine outpatient mental health and substance use services (includes behavioral health treatment, electroconvulsive therapy, intensive outpatient programs, partial hospitalization programs, transcranial magnetic stimulation, post discharge ancillary care and psychological testing. For partial hospitalization programs, a higher copayment and facility charges may apply per episode of care. Some services may require prior authorization and facility charges)	No Charge
SUBSTANCE USE DISORDER SERVICES[8]	
Inpatient hospital services f (prior authorization is required)	20% (subject to the calendar year medical deductible)
Residential care (prior authorization is required)	20% (subject to the calendar year medical deductible)
Inpatient professional (physician) services (prior authorization required)	20% (subject to the calendar year medical deductible)
Routine outpatient substance use disorder services (includes professional/physician visits; some services may require prior authorization and facility charges)	$45 per visit
Non-routine outpatient substance use disorder services (includes intensive outpatient programs, partial hospitalization programs, office-based opioid treatment, and post discharge ancillary care. For partial hospitalization programs, a higher copayment and facility charges may apply per episode of care. Some services may require prior authorization and facility charges)	No Charge
HOME HEALTH SERVICES	
Home health care agency services (up to 100 visits per calendar year)	$45 per visit
Medical supplies (see "prescription drug coverage" for specialty drugs)	No Charge
HOSPICE PROGRAM BENEFITS	
Routine home care	No Charge
Inpatient respite care	No Charge
24-hour continuous home care	No Charge
Short-term inpatient care for pain and symptom management	No Charge
CHIROPRACTIC BENEFITS	
Chiropractic services	Not Covered

ACUPUNCTURE BENEFITS	
Acupuncture services (benefits provided are for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain only)	$45 per visit
PREGNANCY AND MATERNITY CARE BENEFITS	
Prenatal and preconceptionl physician office visits (for inpatient hospital services, see "Hospitalization Services")	No Charge
Delivery and all inpatient physician services	20% (subject to the calendar year medical deductible)
Postnatal physician office visits (for inpatient hospital services, see "Hospitalization Services")	$45 per visit
Abortion services (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)	20%
FAMILY PLANNING AND INFERTILITY BENEFITS	
Counseling and consulting (includes insertion of IUD, as well as injectable and implantable contraceptives for women)	No Charge
Infertility services[1] (Diagnosis and treatment of cause of infertility. Excludes services such as in vitro fertilization. Member share of cost for self-administered drugs for infertility is described under “Prescription Drug Coverage“)	50%
Tubal ligation	No Charge
Vasectomy (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)	20%
REHABILITATION/HABILITATION BENEFITS (Physical, Occupational, and Respiratory Therapy)	
Office location	$45 per visit
SPEECH THERAPY BENEFITS	
Office location	$45 per visit
DIABETES CARE BENEFITS	
Devices, equipment, and non-testing supplies (member share is based upon allowed charges; for testing supplies see “Prescription Drug Coverage“)	20%
Diabetes self-management training in an office setting	$45 per visit
URGENT CARE BENEFITS (BlueCard® Program)	
Urgent services outside your personal physician service area	$90 per visit

PEDIATRIC VISION BENEFITS[17] - 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[13]: 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)	No Charge
Optometric - New patient exams (92002/92004) - Established patient exams (92012/92014)	No Charge
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, plastic, or polycarbonate lenses, all lens powers (single vision, bifocal, trifocal, lenticular), fashion and gradient tinting, scratch coating, oversized and glass-grey #3 prescription sunglass lenses.	No Charge
Optional Lenses and Treatments	
UV coating	No Charge
Anti-reflective coating	$35
High-index lenses	$30
Photochromic lenses - plastic	$25
Photochromic lenses - glass	$25
Polarized lenses	$45
Standard progressives	$55
Premium progressives	$95

Frame [14] (one frame per calendar year)	
Collection frames 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.	No Charge
Non-Collection frames (V2020)	Up to $150 Maximum Allowance
Contact Lenses[15]	
Non-Elective (Medically Necessary) – hard or soft One pair per calendar year	No Charge
Elective (Cosmetic/Convenience) – standard hard (V2500, V2510) One pair per calendar year	No Charge
Elective (Cosmetic/Convenience) – non-standard hard (V2501-V2503, V2511-V2513, V2530-V2531) One pair per calendar year	No Charge
Elective (Cosmetic/Convenience) – standard soft (V2520) One pair per month, up to 6 months, per calendar year	No Charge
Elective (Cosmetic/Convenience) – non-standard soft (V2521-V2523) One pair per month, up to 3 months, per calendar year	No Charge
Other Pediatric Vision Benefits	
Supplemental low-vision testing and equipment [16]	35%
Diabetes management referral	No Charge

PEDIATRIC DENTAL BENEFITS[18] - 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.

Child Dental Diagnostic and Preventive	
Oral exam	No Charge
Preventive – cleaning	No Charge
Preventive - x-ray	No Charge
Sealants per tooth	No Charge
Topical fluoride application	No Charge
Caries risk management	No Charge
Space maintainers – fixed	No Charge
Child Dental Basic Services	
Amalgam fill - 1 surface[20]	$25
Child Dental Major Services[19]	
Root canal – molar	$300
Gingivectomy per quad	$150
Extraction - single tooth exposed root or erupted	$65
Extraction - complete bony	$160
Porcelain with metal crown	$300
Child Orthodontics[19,21]	
Medically necessary orthodontics	$1000

OPTIONAL BENEFITS

Optional dental and vision benefits are available. If your employer purchased any of these benefits, a description of the benefit is provided separately.

1. For family coverage, there is an individual medical deductible and a separate individual pharmacy deductible within the family medical and pharmacy deductibles. This means that the medical and pharmacy deductibles will be met for an individual who meets the individual medical and pharmacy deductibles prior to meeting the family medical and pharmacy deductibles. 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
   - Family planning benefits: infertility services

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 exact terms and conditions of coverage.

2. 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.

3. 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

4. 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.

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. 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.

7. Contraceptive drugs and devices covered under the outpatient prescription drug benefits do not require a copayment and are not subject to the calendar year medical deductible. However, if a brand contraceptive is selected when a generic equivalent is available; the member is responsible for paying the difference between the cost to Blue Shield for the brand contraceptive and its generic 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. 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. For a listing of severe mental illnesses, including serious emotional disturbances of a child, and other benefit details, please refer to the Summary of Benefits and *Evidence of Coverage*. Inpatient services for acute medical detoxification are covered under the medical benefit; see the Hospital Benefits (Facility Services) section of the *Evidence of Coverage* for benefit details. Services for acute medical detoxification are accessed through Blue Shield using Blue Shield participating providers.

9. 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 Specialy Drug copayment or coinsurance will be pro-rated.

10. If the member or physician selects a brand drug when a generic drug equivalent is available, the member is responsible for paying the difference in cost between the brand drug and its generic 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 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. Refer to the *Evidence of Coverage* and Summary of Benefits for details.

11. 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.

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

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

14, 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.

15. 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.

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

17. 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.

18. Pediatric dental benefits are available through a DHMO network of participating dentists. With the exception of emergency dental services, all dental services must be provided through a participating dentist in this DHMO 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.

    Members should contact Dental Plan Member Services if they need assistance locating a Dental Plan Provider in the Service Area. Refer to the *Evidence of Coverage and Summary of Benefits* for details. The Plan will review and consider the request for services that cannot be reasonably obtained in network.

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

19. There are no waiting periods for major & orthodontic services.

20. Posterior composite resin, or acrylic restorations are optional services, and Blue Shield will only pay the amalgam filling rate while the member will be responsible for the difference in cost between the posterior composite resin and amalgam filling.

21. Medically necessary orthodontia services include an oral evaluation and diagnostic casts. An initial orthodontic examination (a limited oral evaluation) must be conducted which includes completion of the Handicapping Labio-Lingual Deviation (HLD) score sheet. The HLD score sheet is the preliminary measurement tool used in determining if the member qualifies for medically necessary orthodontic services (see list of qualifying conditions below). Diagnostic casts may be covered only if qualifying conditions are present. Pre-certification for all orthodontia evaluation and services is required.

    Those immediate qualifying conditions are:

    - Cleft lip and or palate deformities
    - Craniofacial anomalies including the following: Crouzon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, Hemi-facial atrophy, Hemi-facial hypertrophy and other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants.
    - Deep impinging overbite, where the lower incisors are destroying the soft tissue of the palate and tissue laceration and/or clinical attachment loss are present. (Contact only does not constitute deep impinging overbite.)
    - Crossbite of individual anterior teeth when clinical attachment loss and recession of the gingival margin are present (e.g., stripping of the labial gingival tissue on the lower incisors). Treatment of bi-lateral posterior crossbite is not a benefit of the program.
    - Severe traumatic deviation must be justified by attaching a description of the condition.
    - Overjet greater than 9mm or mandibular protrusion (reverse overjet) greater than 3.5mm.
    - The remaining conditions must score 26 or more to qualify (based on the HLD Index).

Plan designs may be modified to ensure compliance with state and federal requirements.

This plan is pending regulatory approval.