



Blue Shield POS \$300 Deductible Plan

Benefits and Coverage Matrix

THIS BLUE SHIELD POS PLAN IS AVAILABLE TO GROUPS WITH TWO OR MORE ELIGIBLE EMPLOYEES

NETWORK BENEFITS (HMO PLAN PROVIDERS) ¹					
Calendar Year Deductible	Prescription Drug Coverage ^{10#}	Mail-Order Drug Coverage ^{10#}	Calendar Year Copayment Maximum [#]		
<small>(The deductible does not apply to the Calendar Year Copayment Maximum.)</small>					
None	\$10 Generic \$20 Formulary Brand	\$20 Generic \$40 Formulary Brand	\$1,000 Individual \$2,000 Family		
IN PPO NETWORK & OUT OF PPO NETWORK ¹ Member use of Plan and Non-Plan Providers [*]					
Plan	Calendar Year Deductible	Prescription Drug Coverage (30-day supply) ^{10#}	Mail-Order Drug Coverage (90-day supply) ^{10#}	Calendar Year Copayment Maximum [#]	
	<small>(The deductible does not apply to the Calendar Year Copayment Maximum.)</small>				
		not subject to the deductible; includes oral contraceptives, diaphragms and covered diabetic testing supplies			
I	\$300 Individual/ \$600 Family	\$10 Generic \$20 Formulary Brand	\$20 Generic \$40 Formulary Brand	\$4,000 Individual	\$8,000 Family

	Network Benefits ¹ : HMO Plan Providers	Unlimited	In PPO Network & Out of PPO Network ¹ : Member Use of Plan and Non-Plan Providers [*]	\$2,000,000
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COVERED SERVICES	Network Benefits ¹ : HMO Plan Providers	In PPO Network & Out of PPO Network ¹ : Member Use of Plan and Non-Plan Providers [*]
PROFESSIONAL SERVICES		
Physician Services – Outpatient		
– Primary care office visits/consultations	\$10/visit	30% ⁴
– Specialist visits/consultations	\$10/visit	30% ⁴
– Allergy testing/treatment ⁵	\$10/visit	30% ⁴
– Injectable medications (other than injectables for allergy ⁵)	No Charge	30% ⁴
Laboratory, X-rays, diagnostic tests	No Charge	30%
Preventive Care		
– Scheduled Routine Physical Exams, including gynecological, Well-baby, child and adult exams according to age schedule (A woman may self-refer to an OB/GYN or Family Practice Physician in her Personal Physician's Medical Group or IPA for annual gynecological exams.)	No Charge	Not Covered
– Immunizations	No Charge	Not Covered
– Vision and hearing screenings up to age 18	No Charge	Not Covered
OUTPATIENT SERVICES		
Non-Emergency		
– Outpatient surgery	\$50/surgery ²	30% ^{4,6}
– Outpatient treatment, renal dialysis and necessary supplies	No Charge ³	30% ^{4,6}
HOSPITALIZATION SERVICES		
– Inpatient physician visits and consultations	No Charge	30% ⁴
– Surgeons and assistants, anesthesiologists, pathologists, radiologists	No Charge	30% ⁴
– Semiprivate room and board, medically necessary services and supplies, including subacute care	No Charge ²	30% ^{4,6}
EMERGENCY HEALTH COVERAGE (waived if directly admitted to the hospital as an inpatient)	\$50/visit	\$50/visit
AMBULANCE SERVICES	\$50	30%
DURABLE MEDICAL EQUIPMENT		
– Home medical equipment, prosthetics/orthotics, oxygen, colostomy/ostomy supplies	50% of Allowed Charges	50%

COVERED SERVICES

MEMBER COPAYMENT

MENTAL HEALTH SERVICES (PSYCHIATRIC)⁷

- Inpatient services
- Outpatient visits for severe mental health conditions
- Outpatient visits for non-severe mental health conditions
(up to 20 visits per calendar year combined with outpatient chemical dependency visits)

Network Benefits:
MHPA Participating
Providers¹
No Charge
\$10/visit
\$50/visit[#]

In PPO Network & Out of
PPO Network: MHPA
Non-Participating Providers¹
30%⁶
30%
50%[#]

CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)⁷

- Inpatient services for medical acute detoxification
- Outpatient visits (up to 20 visits per calendar year combined with outpatient non-severe mental health visits)

See "Hospitalization Services"
\$50/visit[#]

50%[#]

HOME HEALTH SERVICES

- Agency visits (up to 100 visits per calendar year)
- Medical supplies/IV solutions

Network Benefits¹:
HMO Plan Providers
\$10/visit
No Charge

In PPO Network & Out of PPO
Network¹: Member Use of Plan
and Non-Plan Providers*
30%
30%

HOSPICE¹¹

- Routine Home Care and Inpatient Respite Care
- 24-Hour Continuous Home Care and General Inpatient Care

No Charge
No Charge

Not Covered
Not Covered

OTHER

Pregnancy and Maternity Care

- Prenatal and postnatal physician office visits
- All necessary inpatient hospital services

No Charge

30%⁴
See "Hospitalization Services"

Family Planning and Infertility Services

- Family planning counseling
- Diagnosis and treatment of cause of infertility⁸
- Elective abortion, tubal ligation⁹
- Vasectomy

No Charge
50%
\$100¹³
\$75¹³

Not Covered
Not Covered
50%
50%

Rehabilitative Therapy Services – Physical, Speech, Occupational and Respiratory Therapy

- In office
- In rehab unit of hospital
- In Skilled Nursing Facility (SNF) rehab unit¹²

\$10/visit
No Charge

30%⁴
See "Hospitalization Services"
30%⁶

Skilled Nursing Facility (SNF) Services (up to 100 days per calendar year)¹²

No Charge

30%⁶

Diabetes Care

- Equipment, devices and non-testing supplies (for testing supplies, please see "Prescription Drug Coverage")
- Self-management training and education

50% of Allowed Charges
\$10/visit

50%
30%⁴

Urgent Care Outside Service Area (BlueCard Program)

\$50/visit

30%

* In PPO Network & Out of PPO Network providers consist of Plan (Preferred Choice and Preferred Affiliated) and Non-Plan (Non-Preferred & Non-Participating) Providers.

[#] Copayments and charges for services not included in the calculation of the member's Calendar-Year Copayment Maximum continue to be the member's responsibility after the Calendar-Year Copayment Maximum is reached.

¹ Member is responsible for copayment in addition to any charges above Allowable Amounts. The copayment percentage indicated is a percentage of allowed amounts. Plan Providers accept Blue Shield's Allowable Amount as full payment for covered services. Non-Plan Providers can charge more than these amounts. When members use Non-Plan Providers, they must pay the applicable copayment plus any amount that exceeds Blue Shield's Allowable Amount. Charges above the Allowable Amount do not count toward the calendar-year deductible or Copayment Maximum. The calendar-year deductible applies to the combined services of and In PPO Network & Out of PPO Network Plan and Non-Plan Providers. Mental health and chemical dependency services, other than medical acute detoxification, are accessed through the Mental Health Services Administrator (MHPA) utilizing MHPA Participating and Non-Participating Providers. There are no In PPO Network & Out of PPO Network Plan providers for mental health and chemical dependency services, other than for medical acute detoxification.

² Network Benefits: There are Choice and Affiliated hospitals. An additional \$100 member copayment per day, visit or surgery will be charged for non-emergency hospital services obtained from an Affiliated Provider. The additional \$100 member copayment per day charge is limited to a 7 days per Calendar Year maximum. Services received from Affiliated Providers do not apply to the calendar year copayment maximum.

³ Network Benefits: An additional \$10 member copayment per visit will apply for all non-emergency outpatient treatment obtained from an Affiliated Provider. Services received from an Affiliated Provider do not apply to the calendar year copayment maximum.

⁴ In PPO Network & Out of PPO Network: There are Choice and Affiliated PPO providers. An additional 10% member copayment will be charged when non-emergency professional or hospital facility services are obtained from an Affiliated Provider.

⁵ Injectables and serum for treatment of allergies are also covered. When performed or arranged by the Personal Physician, the member copayment is 50% of Allowed Charges. When members self-refer to an In PPO Network & Out of PPO Network Plan or Non-Plan Provider, they pay 50% of the Allowable Amount.

⁶ The maximum allowed charge for non-emergency hospital services received from a Non-Plan Provider-Hospital is \$600 per day. Members are responsible for 30% of this \$600 per day, plus all charges in excess of \$600. These payments do not count toward the calendar-year Copayment Maximum, and continue to be charged after it is reached. For Physician Services, which are covered separately, members pay 30% of Allowable Amounts.

⁷ Mental health and chemical dependency services, other than medical acute detoxification, are accessed through the MHPA. Services for medical acute detoxification are accessed through Blue Shield using Blue Shield's HMO Plan Providers, and In PPO Network & Out of PPO Network Plan or Non-Plan Providers. For a listing of Severe Mental Illnesses, including Serious Emotional Disturbances of a Child, and other benefit details, please refer to the Evidence of Coverage or Plan Contract.

⁸ *In vitro* fertilization, injectables for infertility, artificial insemination and GIFT are excluded. See page 43 for information about the optional infertility benefit.

⁹ Copayment does not apply when performed in conjunction with delivery or abdominal surgery.

¹⁰ Only drugs on the *Blue Shield Drug Formulary* are covered, unless prior authorized by Blue Shield Pharmacy Service. If the physician or member requests a brand name drug and a generic is available, the member is responsible for the difference in cost between the brand and the generic in addition to the generic copayment. Drugs from non-participating pharmacies are not covered.

¹¹ Covered Hospice Services received from any Hospice agency must be prior authorized by Blue Shield. If Blue Shield prior authorizes Hospice services from a Non-Plan Hospice Agency, those hospice services will be reimbursed at Participating Hospice Agency level.

¹² Skilled Nursing services are limited to 100 days during any Calendar Year except when received through a Hospice Program provided by a Participating Hospice Agency. This 100 day maximum on skilled nursing services is a combined maximum between Hospital and Skilled Nursing Facilities.

¹³ Physician services copayment in the office or outpatient hospital facility only. If procedure is performed in an inpatient hospital facility setting, additional hospital services copayment will apply.

This chart only briefly describes the benefits of the Blue Shield POS \$300 Deductible Plan. Please see the Evidence of Coverage, the Disclosure Form, and the Group Health Service Contract for the exact terms and conditions of coverage.

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

