

# Blue Shield POS Plan E (80/60)

## Benefits and Coverage Matrix

THESE BLUE SHIELD POS PLANS ARE AVAILABLE TO GROUPS WITH TWO OR MORE ELIGIBLE ENROLLED EMPLOYEES

BLUE SHIELD HMO (LEVEL I BENEFITS)			
Calendar Year Deductible	Prescription Drug Coverage <sup>10#</sup>	Mail-Order Drug Coverage <sup>10#</sup>	Calendar Year Copayment Maximum <sup>#</sup>
None	Depends upon Plan Selected for Opt-Out Benefits (see below)		\$1,000 Individual \$2,000 Family

PREFERRED AND NON-PREFERRED BENEFITS (LEVEL II AND LEVEL III BENEFITS)					
Plan	Calendar Year Deductible	Prescription Drug Coverage (30-day supply) <sup>10#</sup>	Mail-Order Drug Coverage (90-day supply) <sup>10#</sup>	Calendar Year Copayment Maximum <sup>#</sup>	
				Preferred Provider	Non-Preferred Provider
I	\$300 Individual/ \$600 Family	not subject to the deductible; includes oral contraceptives, diaphragms and covered diabetic testing supplies \$10 Generic \$15 Formulary Brand	\$20 Generic \$30 Formulary Brand	\$2,000 Individual \$4,000 Family	\$5,000 Individual \$10,000 Family
II	\$500 Individual/ \$1,000 Family	\$10 Generic \$20 Formulary Brand	\$20 Generic \$40 Formulary Brand	\$2,000 Individual \$4,000 Family	\$5,000 Individual \$10,000 Family

LIFETIME BENEFIT MAXIMUM:	Level I	Level II	Level III
	Unlimited	\$2,000,000	

COVERED SERVICES	MEMBER COPAYMENT		
	Level I HMO Plan Providers <sup>1</sup>	Level II Preferred Providers <sup>1</sup>	Level III Non-Preferred Providers <sup>1</sup>
<b>PROFESSIONAL SERVICES</b>			
<b>Physician Services – Outpatient</b>			
– Primary care office visits/consultations	\$10/visit	20% <sup>4</sup>	40%
– Specialist visits/consultations	\$10/visit	20% <sup>4</sup>	40%
– Allergy testing/treatment <sup>2</sup>	\$10/visit	20% <sup>4</sup>	40%
– Injectable medications (other than injectables for allergy <sup>2</sup> )	No Charge	20% <sup>4</sup>	40%
<b>Laboratory, X-rays, diagnostic tests</b>	No Charge	20%	40%
<b>Preventive Care</b>			
– 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	Not Covered
– Immunizations	No Charge	Not Covered	Not Covered
– Vision and hearing screenings up to age 18	No Charge	Not Covered	Not Covered
<b>OUTPATIENT SERVICES</b>			
<b>Non-Emergency</b>			
– Outpatient surgery	\$50 <sup>2</sup>	20% <sup>4</sup>	40% <sup>6</sup>
– Outpatient treatment and renal dialysis	No Charge <sup>3</sup>	20% <sup>4</sup>	40% <sup>6</sup>
<b>HOSPITALIZATION SERVICES</b>			
– Inpatient physician visits and consultations	No Charge	20% <sup>4</sup>	40%
– Surgeons and assistants, anesthesiologists, pathologists, radiologists	No Charge	20% <sup>4</sup>	40%
– Semiprivate room and board, medically necessary services and supplies, including subacute care	No Charge <sup>2</sup>	20% <sup>4</sup>	40% <sup>6</sup>
<b>EMERGENCY HEALTH COVERAGE</b> (waived if directly admitted to the hospital as an inpatient)	\$50/visit	\$50/visit	\$50/visit
<b>AMBULANCE SERVICES</b>	\$50	20%	20%
<b>DURABLE MEDICAL EQUIPMENT</b>			
– Home medical equipment, prosthetics/orthotics, oxygen, colostomy/ostomy supplies	50% of Allowed Charges	50%	50%

## COVERED SERVICES

## MEMBER COPAYMENT

	Level I MHSAs Participating Providers <sup>1</sup>	Level II N/A <sup>1</sup> except for medical acute detoxification	Level III MHSAs Non-Participating Providers <sup>1</sup>
<b>MENTAL HEALTH SERVICES (PSYCHIATRIC)<sup>7</sup></b>			
– Inpatient services	No Charge	N/A	40% <sup>6</sup>
– Outpatient visits for severe mental health conditions	\$10/visit	N/A	40%
– Outpatient visits for non-severe mental health conditions (up to 20 visits per calendar year combined with chemical dependency visits)	\$50/visit	N/A	50%
<b>CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)<sup>7</sup></b>			
– Inpatient services for medical acute detoxification		See “Hospitalization Services”	
– Outpatient visits (up to 20 visits per calendar year combined with non-severe mental health visits)	\$50/visit	N/A	50%
<b>HOME HEALTH SERVICES</b>			
– Agency visits (up to 100 visits per calendar year)	Level I HMO Plan Providers <sup>1</sup> \$10/visit	Level II Preferred Providers <sup>1</sup> 20%	Level III Non-Preferred Providers <sup>1</sup> 40%
– Medical supplies/IV solutions	No Charge	20%	40%
– Physician home visits	\$25/visit	20%	40%
<b>HOSPICE<sup>11</sup></b>			
– Routine Home Care and Inpatient Respite Care	No Charge	Not Covered	Not Covered
– 24-Hour Continuous Home Care and General Inpatient Care	No Charge	Not Covered	Not Covered
<b>OTHER</b>			
<b>Pregnancy and Maternity Care</b>			
– Prenatal and postnatal physician office visits	No Charge	20% <sup>4</sup>	40%
– All necessary inpatient hospital services		See “Hospitalization Services”	
<b>Family Planning and Infertility Services</b>			
– Family planning counseling	No Charge	Not Covered	Not Covered
– Diagnosis and treatment of cause of infertility <sup>8</sup>	50%	Not Covered	Not Covered
– Tubal ligation <sup>9</sup> , elective abortion	\$100 <sup>2</sup>	50%	50%
– Vasectomy	\$75 <sup>2</sup>	50%	50%
<b>Rehabilitative Therapy Services – Physical, Speech, Occupational and Respiratory Therapy</b>			
– In office	\$10/visit	20% <sup>4</sup>	40%
– In rehab unit of hospital		See “Hospitalization Services”	
– In Skilled Nursing Facility (SNF) rehab unit <sup>12</sup>	No Charge	20%	40%
<b>Skilled Nursing Facility (SNF) Services</b> (up to 100 days per calendar year) <sup>12</sup>	No Charge	20%	40%
<b>Diabetes Care</b>			
– Equipment, devices and non-testing supplies (for testing supplies, please see “Prescription Drug Coverage”)	50%	50%	50%
– Self-management training and education	\$10/visit	20% <sup>4</sup>	40%
<b>Urgent Care Outside Service Area</b> (BlueCard Program)	\$50/visit	20%	40%

<sup>#</sup> 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.

<sup>1</sup> Member is responsible for copayment or coinsurance in addition to any charges above Allowable Amounts. The coinsurance percentage indicated is a percentage of allowed amounts. Preferred Providers accept Blue Shield’s Allowable Amount as full payment for covered services. Non-Preferred Providers can charge more than these amounts. When members use Non-Preferred 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 Preferred and Non-Preferred Providers. Mental health and chemical dependency services, other than medical acute detoxification, are accessed through the Mental Health Services Administrator (MHSAs) utilizing MHSAs Participating (Level I) and MHSAs Non-Participating Providers (Level III). Inpatient services for medical acute detoxification are accessed through Blue Shield using Blue Shield HMO Plan Providers (Level I), Preferred Providers (Level II), or Non-Preferred Providers (Level III).

<sup>2</sup> POS Level I: There are Choice and Affiliated hospitals. An additional \$100 member copayment per day, visit or surgery will be charged for 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.

<sup>3</sup> POS Level I: An additional \$10 member copayment per visit will apply for all outpatient treatment obtained from an Affiliated Provider. Services received from Affiliated Providers do not apply to the calendar year copayment maximum.

<sup>4</sup> POS Level II: There are Choice and Affiliated PPO providers. An additional 10% coinsurance will be charged when professional or hospital facility services are obtained from an Affiliated Provider.

<sup>5</sup> 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 a Preferred or Non-Preferred Provider, they pay 50% of the Allowable Amount.

<sup>6</sup> The maximum allowed charge for non-emergency hospital services received from a Non-Preferred Hospital is \$600 per day. Members are responsible for 40% 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 40% of Allowable Amounts.

<sup>7</sup> 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.

<sup>8</sup> *In vitro* fertilization, injectables for infertility, artificial insemination and GIFT are excluded. See page 40 for information about the optional infertility benefit.

<sup>9</sup> Copayment does not apply when performed in conjunction with delivery or abdominal surgery.

<sup>10</sup> Only drugs on the *Blue Shield Drug Formulary* are covered, unless prior authorized by Blue Shield Pharmacy Service. If a member requests a brand name drug when a generic equivalent is available, the member will be charged the difference in cost between the brand name and the generic drug, plus the copayment for brand name drugs. Drugs from non-participating pharmacies are not covered.

<sup>11</sup> 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-Participating Hospice Agency, those Hospice Services will be reimbursed at Participating Hospice Agency level.

<sup>12</sup> 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.

*This chart only briefly describes the benefits of the Blue Shield POS 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.*



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