Blue Shield $0 Cost-Share HMO AI-AN

This plan is only available to eligible Native Americans [1]

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.

	Native American Providers [2]	Plan Providers
Calendar Year Medical Deductible	$0	$0
Calendar Year Out-of-Pocket Maximum	$0	$0
Lifetime Benefit Maximum	None	None

Covered Services	Member Copayment	
	Native American Provider [2]	Plan Providers
PROFESSIONAL SERVICES		
Professional Benefits		
Primary care physician office visit (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)	$0	No Charge
Other practitioner office visit	$0	No Charge
Specialist physician office visit (see also the **Access+ *Specialist*^{SM} Benefit** below)	$0	No Charge
Teladoc consultation	Not Covered	No Charge
Allergy Testing and Treatment Benefits		
Primary care physician office visits (includes visits for allergy serum injections)	$0	No Charge
Specialist physician office visits (includes visits for allergy serum injections)	$0	No Charge
Allergy serum purchased separately for treatment	$0	No Charge
Access+ *Specialist*^{SM} Benefits [3]		
Office visit, examination or other consultation (self-referred office visits and consultations only)	$0	No Charge
Preventive Health Benefits		
Preventive health services (as required by applicable Federal and California law)	$0	No Charge
OUTPATIENT SERVICES		
Hospital Benefits (Facility Services)		
Outpatient surgery performed at a free-standing ambulatory surgery center [4]	$0	No Charge
Outpatient surgery performed in a hospital or a hospital affiliated ambulatory surgery center [4]	$0	No Charge
Outpatient visit	$0	No Charge

Covered Services	Member Copayment	
	Native American Provider [2]	**Plan Providers**
Outpatient services for treatment of illness or injury and necessary supplies (except as described under "Rehabilitation Benefits" and "Speech Therapy Benefits")	$0	No Charge
CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine performed in a hospital (prior authorization required)	$0	No Charge
Outpatient diagnostic x-ray and imaging performed in a hospital	$0	No Charge
Outpatient diagnostic laboratory and pathology performed in a hospital	$0	No Charge
HOSPITALIZATION SERVICES		
Hospital Benefits (Facility Services)		
Inpatient physician fee	$0	No Charge
Inpatient non-emergency facility fee (semi-private room and board, and medically necessary services and supplies, including sub-acute care)	$0	No Charge
INPATIENT SKILLED NURSING BENEFITS [5] (combined maximum of up to 100 days per benefit period; prior authorization required; semi-private accommodations)		
Services by a free-standing skilled nursing facility	$0	No Charge
Skilled nursing unit of a hospital	$0	No Charge
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)	$0	No Charge
Emergency room visit resulting in admission – facility fee (when the Member is admitted directly from the Emergency Room)	$0	No Charge
Emergency room visit not resulting in admission - physician fee (copayment does not apply if the Member is directly admitted to the hospital for inpatient services)	$0	No Charge
Emergency room visit resulting in admission - physician fee	$0	No Charge
AMBULANCE SERVICES		
Emergency or authorized transport (ground or air)	$0	No Charge
PRESCRIPTION DRUG (PHARMACY) COVERAGE [6, 7, 8, 9, 10, 11, 12]	**Native American Pharmacy [2]**	**Plan Pharmacy**
Retail Pharmacies (up to a 30-day supply)		
Contraceptive drugs and devices [7]	$0	No Charge
Tier 1 Drugs	$0	No Charge
Tier 2 Drugs	$0	No Charge
Tier 3 Drugs	$0	No Charge
Tier 4 Drugs (excluding Specialty Drugs)	$0	No Charge
Mail Service Pharmacies (up to a 90-day supply)		
Contraceptive drugs and devices [7]	$0	No Charge
Tier 1 Drugs	$0	No Charge
Tier 2 Drugs	$0	No Charge
Tier 3 Drugs	$0	No Charge
Tier 4 Drugs (excluding Specialty Drugs)	$0	No Charge
Network Specialty Pharmacies [9, 10, 11] (up to a 30-day supply)		
Tier 4 Drugs	$0	No Charge
Oral anticancer medications	$0	No Charge
	Native American Provider [2]	**Plan Providers**
PROSTHETICS/ORTHOTICS		
Prosthetic equipment and devices (separate office visit copayment may apply)	$0	No Charge
Orthotic equipment and devices (separate office visit copayment may apply)	$0	No Charge
DURABLE MEDICAL EQUIPMENT		
Breast pump	$0	No Charge
Other durable medical equipment (Member share is based upon allowed charges)	$0	No Charge

Covered Services	Member Copayment	
	Native American Provider [2]	Plan Providers
MENTAL HEALTH AND BEHAVIORAL HEALTH SERVICES [13]		
Inpatient hospital services (prior authorization required)	$0	No Charge
Residential care (prior authorization required)	$0	No Charge
Inpatient professional (physician) services (prior authorization required)	$0	No Charge
Routine outpatient mental health and behavioral health services (includes professional/physician visits; some services may require prior authorization and facility charges)	$0	No Charge
Non-routine outpatient mental health and behavioral health services (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	No Charge
SUBSTANCE USE DISORDER SERVICES [13]		
Inpatient hospital services (prior authorization required)	$0	No Charge
Residential care (prior authorization required)	$0	No Charge
Inpatient professional (physician) services (prior authorization required)	$0	No Charge
Routine outpatient substance use disorder services (includes professional/physician visits; some services may require prior authorization and facility charges)	$0	No Charge
Non-routine outpatient substance use disorder services (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	No Charge
HOME HEALTH SERVICES		
Home health care agency visits (up to 100 prior authorized visits per calendar year)	$0	No Charge
Home infusion/home intravenous injectable therapy	$0	No Charge
Home infusion nursing visits provided by a home infusion agency	$0	No Charge
HOSPICE PROGRAM BENEFITS		
Routine home care	$0	No Charge
Inpatient respite care	$0	No Charge
24-hour continuous home care	$0	No Charge
Short-term inpatient care for pain and symptom management	$0	No Charge
CHIROPRACTIC BENEFITS		
Chiropractic services	Not Covered	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)	$0	No Charge
REHABILITATION AND HABILITATIVE BENEFITS (Physical, Occupational, and Respiratory Therapy)		
Office location	$0	No Charge
SPEECH THERAPY BENEFITS		
Office location	$0	No Charge
PREGNANCY AND MATERNITY CARE BENEFITS		
Prenatal and preconception physician office visits (for inpatient hospital services, see "Hospitalization Services")	$0	No Charge
Delivery and all inpatient physician services	$0	No Charge
Postnatal physician office visit: initial visit (for inpatient hospital services, see "Hospitalization Services")	$0	No Charge
Abortion services (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)	$0	No Charge

Covered Services	Member Copayment	
	Native American Provider [2]	Plan Providers
FAMILY PLANNING BENEFITS		
Counseling, consulting, and education (includes insertion of IUD, as well as injectable and implantable contraceptives for women)	$0	No Charge
Tubal ligation	$0	No Charge
Vasectomy (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)	$0	No Charge
Infertility services	Not Covered	Not Covered
DIABETES CARE BENEFITS		
Devices, equipment, and non-testing supplies (Member share is based upon allowed charges; for testing supplies see "Prescription Drug Coverage")	$0	No Charge
Diabetes self-management training in an office setting	$0	No Charge
URGENT CARE BENEFITS (BlueCard® Program)		
Urgent services outside your personal physician service area	$0	No Charge
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 (includes dilation, if professionally indicated)		
Ophthalmologic - Routine ophthalmologic exam with refraction – new patient (S0620) - Routine ophthalmologic exam with refraction – established patient (S0621)	$0	No Charge
Optometric - New patient exam (92002/92004) - Established patient exam (92012/92014)	$0	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 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	No Charge
Optional Lenses and Treatments		
UV coating (standard only)	$0	No Charge
Polycarbonate lenses	$0	No Charge
Anti-reflective coating (standard only)	$0	No Charge
High-index lenses	$0	No Charge
Photochromic lenses – plastic	$0	No Charge
Photochromic lenses – glass	$0	No Charge
Polarized lenses	$0	No Charge
Standard progressives	$0	No Charge
Premium progressives	$0	No Charge
Frame [16] (one frame per calendar year)		
Collection frame 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	No Charge
Non-collection frame (V2020)	$0	Covered up to $150 maximum Allowance
Contact Lenses [17]		
Elective (Cosmetic/Convenience) – standard hard (V2500, V2510)	$0	$0
Elective (Cosmetic/Convenience) – standard soft (V2520) (One pair per month, up to 6 months, per Calendar Year)	$0	$0
Elective (Cosmetic/Convenience) – non-standard hard (V2501-V2503, V2511-V2513, V2530-V2531)	$0	$0
Elective (Cosmetic/Convenience) – non-standard soft (V2521-V2523) (One pair per month, up to 3 months, per Calendar Year)	$0	$0
Non-Elective (Medically Necessary) – hard or soft [18]	$0	$0

Covered Services	Member Copayment	
	Native American Provider [2]	Plan Providers
Other Pediatric Vision Benefits		
Comprehensive low vision exam [18] (Once every 5 Calendar Years)	$0	No Charge
Low vision devices [18] (One aid per Calendar Year)	$0	No Charge
Diabetes management referral	$0	No Charge
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	No Charge
Preventive – cleaning	$0	No Charge
Preventive – x-ray	$0	No Charge
Sealants per tooth	$0	No Charge
Topical fluoride application	$0	No Charge
Space maintainers – fixed	$0	No Charge
Basic Services [20]		
Restorative procedures	$0	No Charge
Periodontal maintenance services	$0	No Charge
Major Services [20]		
Crowns and casts	$0	No Charge
Endodontics	$0	No Charge
Periodontics	$0	No Charge
Prosthodontics	$0	No Charge
Oral surgery	$0	No Charge
Orthodontics [20, 21]		
Medically necessary orthodontics	$0	No Charge

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

Endnotes

1. Native American means any individual as defined in section 4(d) of the Indian Self-Determination and Education Assistance Act (Pub. L. 93–638). Eligibility for coverage as a Native American is determined by Covered California.

2. Members enrolled in this plan can access benefits from any provider, including a Blue Shield participating provider or a provider for Native Americans; however, there is no Member cost-sharing for services received from a provider or pharmacy for Native Americans. "Benefits from a provider or pharmacy for Native Americans" refers to those essential health benefits furnished directly by the Indian Health Service (IHS), an Indian Tribe, a Tribal Organization, or an Urban Indian Organization or through referral under contracted health services (each as defined in 25 U.S.C. 1603)

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. For a list of participating vision providers, Members can search in the "Find a Provider" section of blueshieldca.com. 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. If contact lenses 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.

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. 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