Blue Shield Silver 87 HMO

This federally subsidized plan is only available to those whose income is 150-200% above federal poverty level.

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.

	Plan Providers [1]
Calendar Year Medical Deductible [1]	$650 per individual / $1,300 per family
Calendar Year Out-of-Pocket Maximum [2] (Any calendar year medical deductible and any calendar year pharmacy deductible accrues to the calendar year out-of-pocket maximum.)	$2,350 per individual / $4,700 per family
Calendar Year Pharmacy Deductible [1] (Does not apply to contraceptive drugs and devices or oral anticancer medications. 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.)	$50 per individual / $100 per family
Lifetime Benefit Maximum	None

Covered Services	**Member Copayment**
	Plan Providers [1]
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)	$10 per visit
Other practitioner office visit	$10 per visit
Specialist physician office visit (see also the **Access+ *Specialist*^{SM} Benefit** below)	$25 per visit
Teladoc consultation	$5 per consultation
Allergy Testing and Treatment Benefits	
Primary care physician office visits (includes visits for allergy serum injections)	$10 per visit
Specialist physician office visits (includes visits for allergy serum injections)	$25 per visit
Allergy serum purchased separately for treatment	15%
Access+ *Specialist*^{SM} Benefits [3]	
Office visit, examination or other consultation (self-referred office visits and consultations only)	$25 per visit
Preventive Health Benefits	
Preventive health services (as required by applicable Federal and California law)	$0

Covered Services	Member Copayment
	Plan Providers [1]
OUTPATIENT SERVICES	
Hospital Benefits (Facility Services)	
Outpatient surgery performed at a free-standing ambulatory surgery center [4]	15%
Outpatient surgery performed in a hospital or a hospital affiliated ambulatory surgery center [4]	15%
Outpatient visit	15%
Outpatient services for treatment of illness or injury and necessary supplies (except as described under "Rehabilitation Benefits" and "Speech Therapy Benefits")	15%
CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine performed in a hospital (prior authorization required)	$100 per visit
Outpatient diagnostic x-ray and imaging performed in a hospital	$25 per visit
Outpatient diagnostic laboratory and pathology performed in a hospital	$15 per visit
HOSPITALIZATION SERVICES	
Hospital Benefits (Facility Services)	
Inpatient physician fee	15% (Subject to the calendar year medical deductible)
Inpatient non-emergency facility fee (semi-private room and board, and medically necessary services and supplies, including sub-acute care)	15% (Subject to the calendar year medical deductible)
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	15% (Subject to the calendar year medical deductible)
Skilled nursing unit of a hospital	15% (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)	$100 per visit
Emergency room visit resulting in admission – facility fee (when the Member is admitted directly from the Emergency Room)	15% (Subject to the calendar year medical deductible)
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
Emergency room visit resulting in admission – physician fee	$0
AMBULANCE SERVICES	
Emergency or authorized transport (ground or air)	$75 (Subject to the calendar year medical deductible)
PRESCRIPTION DRUG (PHARMACY) COVERAGE [6, 7, 8, 9, 10, 11, 12]	**Plan Pharmacy** [1]
Retail Pharmacies (up to a 30-day supply)	
Contraceptive drugs and devices [7]	$0
Tier 1 Drugs	$5 per prescription
Tier 2 Drugs	$20 per prescription (Subject to the calendar year pharmacy deductible)
Tier 3 Drugs	$35 per prescription (Subject to the calendar year pharmacy deductible)
Tier 4 Drugs (excluding Specialty Drugs)	15% up to $150 maximum per prescription (Subject to the calendar year pharmacy deductible)
Mail Service Pharmacies (up to a 90-day supply)	
Contraceptive drugs and devices [7]	$0
Tier 1 Drugs	$15 per prescription
Tier 2 Drugs	$60 per prescription (Subject to the calendar year pharmacy deductible)
Tier 3 Drugs	$105 per prescription (Subject to the calendar year pharmacy deductible)

Covered Services	Member Copayment
	Plan Providers [1]
Tier 4 Drugs (excluding Specialty Drugs)	15% up to $450 maximum per prescription (Subject to the calendar year pharmacy deductible)
Network Specialty Pharmacies [9, 10, 11] (up to a 30-day supply)	
Tier 4 Drugs	15% up to $150 maximum per prescription (Subject to the calendar year pharmacy deductible)
Oral anticancer medications	15% up to $200 maximum per prescription
PROSTHETICS/ORTHOTICS	
Prosthetic equipment and devices (separate office visit copayment may apply)	15%
Orthotic equipment and devices (separate office visit copayment may apply)	15%
DURABLE MEDICAL EQUIPMENT	
Breast pump	$0
Other durable medical equipment (Member share is based upon allowed charges)	15%
MENTAL HEALTH AND BEHAVIORAL HEALTH SERVICES [13]	
Inpatient hospital services (prior authorization required)	15% (Subject to the calendar year medical deductible)
Residential care (prior authorization required)	15% (Subject to the calendar year medical deductible)
Inpatient professional (physician) services (prior authorization required)	15% (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)	$10 per visit
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
SUBSTANCE USE DISORDER SERVICES [13]	
Inpatient hospital services (prior authorization required)	15% (Subject to the calendar year medical deductible)
Residential care (prior authorization required)	15% (Subject to the calendar year medical deductible)
Inpatient professional (physician) services (prior authorization required)	15% (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)	$10 per visit
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
HOME HEALTH SERVICES	
Home health care agency visits (up to 100 prior authorized visits per calendar year)	$15 per visit
Home infusion/home intravenous injectable therapy	$0
Home infusion nursing visits provided by a home infusion agency	$15 per visit
HOSPICE PROGRAM BENEFITS	
Routine home care	$0
Inpatient respite care	$0
24-hour continuous home care	$0
Short-term inpatient care for pain and symptom management	$0
CHIROPRACTIC BENEFITS	
Chiropractic services	Not Covered

Covered Services	Member Copayment Plan Providers [1]
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)	$10 per visit
REHABILITATION AND HABILITATIVE BENEFITS(Physical, Occupational, and Respiratory Therapy)	
Office location	$10 per visit
SPEECH THERAPY BENEFITS	
Office location	$10 per visit
PREGNANCY AND MATERNITY CARE BENEFITS	
Prenatal and preconception physician office visit (for inpatient hospital services, see "Hospitalization Services")	$0
Delivery and all inpatient physician services	15% (Subject to the calendar year medical deductible)
Postnatal physician office visit: initial visit (for inpatient hospital services, see "Hospitalization Services")	No Charge
Abortion services (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)	15%
FAMILY PLANNING BENEFITS	
Counseling, consulting, and education (includes insertion of IUD, as well as injectable and implantable contraceptives for women)	$0
Tubal ligation	$0
Vasectomy (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)	15%
Infertility services	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")	15%
Diabetes self-management training in an office setting	$0
URGENT CARE BENEFITS (BlueCard® Program)	
Urgent services outside your personal physician service area	$10 per visit
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
Optometric - New patient exam (92002/92004) - Established patient exam (92012/92014)	$0
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
Optional Lenses and Treatments	
UV coating (standard only)	$0
Polycarbonate lenses	$0
Anti-reflective coating (standard only)	$35
High-index lenses	$30
Photochromic lenses – plastic	$0
Photochromic lenses – glass	$25
Polarized lenses	$45
Standard progressives	$0
Premium progressives	$95

Covered Services	Member Copayment Plan Providers [1]
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
Non-collection frame (V2020)	Covered up to $150 maximum Allowance
Contact Lenses [17]	
Elective (Cosmetic/Convenience) –standard hard (V2500, V2510)	$0
Elective (Cosmetic/Convenience) – standard soft (V2520) (One pair per month, up to 6 months, per Calendar Year)	$0
Elective (Cosmetic/Convenience) – non-standard hard (V2501-V2503, V2511-V2513, V2530-V2531)	$0
Elective (Cosmetic/Convenience) – non-standard soft (V2521-V2523) (One pair per month, up to 3 months, per Calendar Year)	$0
Non-Elective (Medically Necessary) - hard or soft [18]	$0
Other Pediatric Vision Benefits	
Comprehensive low vision exam [18] (Once every 5 Calendar Years)	$0
Low vision devices [18] (One aid per Calendar Year)	$0
Diabetes management referral	$0
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
Preventive - cleaning	$0
Preventive - x-ray	$0
Sealants per tooth	$0
Topical fluoride application	$0
Space maintainers - fixed	$0
Basic Services [20]	
Restorative procedures	20%
Periodontal maintenance services	20%
Major Services [20]	
Crowns and casts	50%
Endodontics	50%
Periodontics (other than maintenance)	50%
Prosthodontics	50%
Oral surgery	50%
Orthodontics [20, 21]	
Medically necessary orthodontics	50%

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

Endnotes

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.

   After the calendar year medical deductible is met, the Member is responsible for a copayment or coinsurance from plan providers.

2. For family coverage, 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

   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 additional details.

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. 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.

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 received. 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