$0 Cost Share PPO AI-AN

This plan is only available to eligible Native Americans*

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* SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

This PPO plan does not require the use of a Provider Network.

	Any Provider[1]
Calendar Year Medical Deductible	$0
Calendar Year Out-of-Pocket Maximum	$0
Calendar Year Pharmacy Deductible	$0
Lifetime Benefit Maximum	None

Covered Services	**Member Copayments**
	Any Provider[1]
PROFESSIONAL SERVICES	
Professional Benefits	
Primary care physician office visits	$0
Other practitioner office visit	$0
Specialist physician office visit	$0
CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine (prior authorization is required)	$0
Outpatient diagnostic x-ray and imaging (non-hospital based or affiliated)	$0
Outpatient diagnostic laboratory and pathology (non-hospital based or affiliated)	$0
Allergy Testing and Treatment Benefits	
Primary care physician office visit (includes visits for allergy serum injections)	$0
Specialist physician office visit (includes visits for allergy serum injections)	$0
Allergy serum purchased separately for treatment	$0
Preventive Health Benefits	
Preventive health services (as required by applicable Federal and California law)	$0
OUTPATIENT SERVICES	
Hospital Benefits (Facility Services)	
Outpatient surgery performed at a free-standing ambulatory surgery center	$0
Outpatient surgery performed in a hospital or hospital affiliated ambulatory surgery center	$0
Outpatient visit	$0
Outpatient services for treatment of illness or injury and necessary supplies (except as described under "Rehabilitation Benefits" and "Speech Therapy Benefits")	$0
CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine (prior authorization is required)	$0
Outpatient diagnostic x-ray and imaging performed in a hospital	$0
Outpatient diagnostic laboratory and pathology performed in a hospital	$0
Bariatric surgery[2] (prior authorization is required; medically necessary surgery for weight loss is for morbid obesity only)	$0

Covered Services	Member Copayments
	Any Provider[1]
HOSPITALIZATION SERVICES	
Hospital Benefits (Facility Services)	
Inpatient physician fee	$0
Inpatient non-emergency facility fee (semi-private room and board, services and supplies, including subacute care)	$0
Bariatric surgery[2] (prior authorization is required; medically necessary surgery for weight loss is for morbid obesity only)	$0
Inpatient Skilled Nursing Benefits (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	$0
Skilled nursing unit of a hospital	$0
EMERGENCY HEALTH COVERAGE	
Emergency room visit not resulting in admission - facility fee	$0
Emergency room visit resulting in admission - facility fee (when the member is admitted directly from the ER)	$0
Emergency room visit not resulting in admission - physician fee	$0
Emergency room visit resulting in admission – physician fee	$0
Urgent care	$0
AMBULANCE SERVICES	
Emergency or authorized transport (ground or air)	$0
PRESCRIPTION DRUG (PHARMACY) COVERAGE[3,4]	**Any Pharmacy**
Retail Pharmacies (up to a 30-day supply)	
Contraceptive drugs and devices	$0
Tier 1 Drugs	$0
Tier 2 Drugs	$0
Tier 3 Drugs	$0
Tier 4 Drugs	$0
Mail Service Pharmacies (up to a 90-day supply)	
Contraceptive drugs and devices	$0
Tier 1 Drugs	$0
Tier 2 Drugs	$0
Tier 3 Drugs	$0
Network Specialty Pharmacies (up to a 30-day supply) [4]	
Tier 4 Drugs	$0
Oral anti-cancer medications	$0
	Any Provider[1]
PROSTHETICS/ORTHOTICS	
Prosthetic equipment and devices (separate office visit copayment may apply)	$0
Orthotic equipment and devices (separate office visit copayment may apply)	$0
DURABLE MEDICAL EQUIPMENT	
Breast pump	$0
Other durable medical equipment	$0
MENTAL HEALTH AND BEHAVIORAL HEALTH SERVICES	
Inpatient hospital services (prior authorization required)	$0
Residential care (prior authorization required)	$0
Inpatient professional (physician) services (prior authorization required)	$0
Routine outpatient mental health and behavioral health services (includes professional/physician visits; some services may require prior authorization and facility charges)	$0
Non-routine outpatient mental health and behavioral health 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)	$0
SUBSTANCE USE DISORDER SERVICES	
Inpatient hospital services (prior authorization required)	$0

Covered Services	Member Copayments
	Any Provider[1]
Residential care (prior authorization required)	$0
Inpatient professional (physician) services (prior authorization required)	$0
Routine outpatient substance use disorder services (includes professional/physician visits; some services may require prior authorization and facility charges)	$0
Non-routine outpatient substance use disorder services (services include partial hospitalization program, intensive outpatient program, post-discharge ancillary care and office-based opioid treatment. Higher copayment and facility charges per episode of care may apply for partial hospitalization programs.)	$0
HOME HEALTH SERVICES	
Home health care agency visit (up to 100 prior authorized visits per calendar year)	$0
Home infusion/home intravenous injectable therapy and infusion nursing visits provided by a home infusion agency (up to 100 prior authorized visits per calendar year)	$0
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
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
REHABILITATION AND HABILITATION BENEFITS (Physical, Occupational and Respiratory Therapy)	
Office location	$0
SPEECH THERAPY BENEFITS	
Office location	$0
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	$0
Postnatal physician office visit (for inpatient hospital services, see "Hospitalization Services")	$0
Abortion services (an additional facility copayment may apply when services are rendered in a hospital or outpatient surgery center)	$0
FAMILY PLANNING BENEFITS	
Counseling and consulting (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)	$0
Infertility services	Not Covered
DIABETES CARE BENEFITS	
Devices, equipment, and non-testing supplies (for testing supplies see Outpatient Prescription Drug Benefits)	$0
Diabetes self-management training in an office setting	$0
CARE OUTSIDE OF CALIFORNIA (benefits provided through the BlueCard® Program for out-of-state emergency and non-emergency care are provided at the participating level of the local Blue Plan allowable amount when you use a Blue Cross/Blue Shield provider)	
Within US: BlueCard Program	See Applicable Benefit
Outside of US: BlueCard Worldwide	See Applicable Benefit
Pediatric Vision Benefits[12] – 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[5]: 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 exams (92002/92004) - Established patient exams (92012/92014)	$0

Covered Services	Member Copayments
	Any Provider[1]
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. Polycarbonate lenses are covered in full for eligible members.	$0
Optional Lenses and Treatments	
UV coating (standard only)	$0
Anti-reflective coating (standard only)	$0
High-index lenses	$0
Photochromic lenses (glass or plastic)	$0
Polarized lenses	$0
Standard progressives	$0
Premium progressives	$0
Frame (one frame per calendar year)[6]	
Collection frame	$0
Non-collection frames (V2020)	$0
Contact Lenses[7]	
Elective (Cosmetic/Convenience) – standard hard (V2500, V2510) One pair per calendar year	$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, V2502, V2503, V2511, V2512, V2513, V2599) One pair per calendar year	$0
Elective (Cosmetic/Convenience) – non-standard soft (V2521, V2512, V2523) One pair per month up to 3 months per calendar year	$0
Non-Elective (Medically Necessary) hard or soft One pair per calendar year	$0
Other Pediatric Vision Benefits	
Supplemental low-vision testing and equipment[8]	$0
Diabetes management referral	$0
Pediatric Dental Benefits[13] – 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	**Any Provider**[1]
Oral exam	$0
Preventive - cleaning	$0
Preventive - x-ray	$0
Sealants per tooth	$0
Topical fluoride application	$0
Caries risk management	$0
Space maintainers - fixed	$0
Child Dental Basic Services	
Amalgam fill - 1 surface[10]	$0
Child Dental Major Services[9]	
Root canal - molar	$0
Gingivectomy per quad	$0
Extraction - single tooth exposed root or erupted	$0
Extraction - complete bony	$0
Porcelain with metal crown	$0
Child Orthodontics[9, 11]	
Medically necessary orthodontics	$0

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

Endnotes:

* 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.

1 There is no member cost-sharing for Native Americans covered under this health plan. Members enrolled in this plan can access benefits from any provider, including a Blue Shield participating provider, a non-participating provider, or a provider for Native

Americans. “Benefits from a provider 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).

2 Bariatric surgery is covered when prior authorized by Blue Shield. Refer to the *Evidence of Coverage* and Summary of Benefits for further benefit details.

3 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.

4 Tier 4 drugs are drugs requiring coordination of care, close monitoring, or extensive patient training that generally cannot be met by a retail pharmacy and are available at a Network Specialty Pharmacy. Tier 4 drugs may also require special handling or manufacturing processes, restriction to certain Physicians or pharmacies, or reporting of certain clinical events to the FDA. Tier 4 drugs are generally high cost.

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

6 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.

7 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.

8 A report from the provider and prior authorization from the contracted VPA is required.

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

10 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.

11 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).

12 Members can search for vision care providers in the “Find a Provider” section of blueshieldca.com. All pediatric vision benefits are provided through MESVision, Blue Shield’s Vision Plan Administrator.

13 Members can search for dental network providers 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.

This plan is pending regulatory approval.