



# Active Choice Plan 600

## Uniform Health Plan Benefits & Coverage Matrix

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE CERTIFICATE OF INSURANCE AND POLICY SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

**Please note:** Preferred hospitals are designated as either **Choice** or **Affiliate**, and different copayments may apply. Please see the Glossary for descriptions of **Choice** and **Affiliate** Hospitals.

<b>ACTIVE CHOICE PLAN 600</b> This plan is underwritten by the Blue Shield of California Life & Health Insurance Company.	
<b>CALENDAR-YEAR CREDIT</b>	\$600 (\$1,200 Family)
<b>CREDIT CARRYOVER POLICY</b> (\$600/\$1,200 Max)	Active Choice members may carry over any unused portion of the \$600 (\$1,200 family) credit to the next calendar year. No individual member can use more than \$600 of the \$1,200 Family credit benefit.
<b>CALENDAR-YEAR COPAYMENT MAXIMUM</b>	\$3,500 (\$7,000 Family) with Preferred <b>Choice</b> Providers* All Providers \$5,000 (\$10,000 Family)
<b>COPAYMENTS FOR PREVENTIVE CARE SERVICES<sup>2</sup></b>	\$20 with Preferred Providers Not applicable with Non-Preferred Providers
<b>COINSURANCE FOR ALL OTHER SERVICES</b>	Member pays 100% of the allowable amount from Preferred Providers or the billed amount from Non-Preferred Providers before reaching the copayment maximum. Blue Shield then pays 100% of the allowable amount after the Copayment maximum is reached. <sup>1</sup>
<b>CALENDAR-YEAR BRAND PRESCRIPTION DEDUCTIBLE</b>	\$250 per person
<b>LIFETIME BENEFIT MAXIMUM</b>	\$6,000,000
* This copayment maximum also includes copayments from preferred providers when there is no designation of "Choice Hospitals" and "Affiliate Hospitals."	

### PREVENTIVE CARE SERVICES

For the following services you will pay a \$20 copayment per visit with **preferred** providers, before or after you've met the copayment maximum. If you use a **non-preferred** provider, these services will not be covered by Blue Shield. Copayments for Preventive Care services do not count towards the calendar year copayment maximum or the \$600 (\$1,200 family) credit.

- Annual routine physical (including urinalysis, eye and ear screenings up to age 16) <sup>~2</sup>
- Annual gynecological exam office visit (including Pap test or other approved cervical cancer screening tests, and routine mammography with annual physical or in a separate office visit) <sup>~2</sup>
- Well-baby benefits (up to age 3, including tuberculin tests and immunizations) <sup>~2</sup>
- Immunizations (adult and child) and the immunizing agent

The following services are offered at **no charge** with **preferred** providers

- Osteoporosis screening
- Colorectal cancer screening

**OUTPATIENT PRESCRIPTION DRUGS<sup>7</sup>** (oral contraceptives and diaphragms covered). There is a \$250 individual brand-name prescription drug deductible per year, which does not count towards the copayment maximum or deduct from the \$600 (\$1,200 family) credit.

	For drugs received from a Participating Pharmacy (30-day supply), you pay	For drugs received through the Mail Service, a Prescription Drug Program (60-day supply), you pay	For drugs received from a Non-Participating Pharmacy, you pay
Formulary generic drugs	\$12/prescription	\$24/prescription	Not Covered
Formulary brand-name drugs <sup>8</sup>	\$30/prescription	\$60/prescription	Not Covered
Non-formulary brand-name drugs <sup>8</sup>	\$45 or 50%/prescription (whichever is greater)	\$90 or 50%/prescription (whichever is greater)	Not Covered
Home self-administered injectables <sup>9</sup>	30%	Not available	Not Covered

## FIRST DOLLAR SERVICES: ALL OTHER COVERED SERVICES\*\*

You can use your \$600 (\$1,200 family) credit to pay for First Dollar services received from preferred providers. Please note that there are certain restrictions for services received from non-preferred providers. Once that credit is used, you will pay 100% of the allowable amount for services received from preferred providers or 100% of billed charges for services received from non-preferred providers until you meet the calendar-year copayment maximum. After the annual copayment maximum has been met, these services will be covered by Blue Shield at 100% until you reach the lifetime maximum.

### PROFESSIONAL SERVICES

Physician office visits and visits to specialists, allergy testing and treatment

### OUTPATIENT SERVICES<sup>2</sup>

Non-emergency services, surgery services received in a hospital outpatient or ambulatory surgery center, outpatient X-ray and lab services, speech therapy

### HOSPITALIZATION SERVICES

Inpatient physician visits, inpatient semiprivate room and board, services, and subacute care

### EMERGENCY HEALTH COVERAGE

Outpatient ER facility services, inpatient physician visits, inpatient semiprivate room and board, ambulance services

### DURABLE MEDICAL EQUIPMENT (\$2,000 COMBINED MAXIMUM)<sup>3</sup>

Prosthetic appliances, home medical equipment and orthotic equipment

### MENTAL HEALTH SERVICES<sup>4,5</sup>

Inpatient hospital facility and physician services, outpatient visits for severe mental health conditions

### HOME HEALTH SERVICES

Services received at home for an insured who is housebound and would otherwise require hospitalization (up to 90 visit max; prior authorization is required)

### PREGNANCY AND MATERNITY CARE<sup>6</sup>

Outpatient prenatal and postnatal care, delivery and all necessary inpatient hospital services

### FAMILY PLANNING

Consultations, tubal ligation, vasectomy, elective abortion, injectable contraceptives

### REHABILITATION SERVICES

Provided by MD (in physician's office or a hospital outpatient department), or in the office of a physical therapist, certified occupational therapist or certified respiratory therapist

### ACUPUNCTURE AND CHIROPRACTIC SERVICES

Up to 12 visits per calendar year combined, received from a chiropractor or acupuncturist

### SKILLED NURSING FACILITY (SNF) AND SUBACUTE CARE

Semiprivate accommodations in a hospital or freestanding SNF unit (100 days max per calendar year)

### OUT-OF-STATE SERVICES

Full plan benefits covered nationwide with the BlueCard program

### DIABETES CARE

Diabetes care supplies, self-management training

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

∞ Copayment includes preventive lab services provided or ordered as part of exam. Diagnostic X-ray services, diagnostic examinations, pathology services and clinical laboratory services to diagnose illness or injury are not covered by the Preventive Care Services benefit.

\*\* See the COI for a complete listing of all covered services.

- 1 Member is responsible for fixed dollar copayment or coinsurance in addition to any charges above allowable amounts. The coinsurance indicated is a percentage of the allowable amounts. Preferred providers accept Blue Shield's allowable amount as payment-in-full for covered services. Non-preferred providers can charge more than the allowable amounts. When members use non-preferred providers, they must pay the applicable copayment or coinsurance, plus any charges that exceed Blue Shield Life's allowable amount. Charges above the allowable amount do not count toward calendar-year copayment maximum. Mental health and substance abuse services, other than services for medical acute detoxification, are accessed through the Mental Health Services Administrator (MHSA) utilizing MHSA participating providers. MHSA participating providers agree to accept the MHSA's payment, plus Member's payment of any applicable copayment or coinsurance, or amounts in excess of benefit dollar maximums specified, as payment-in-full for covered mental health and substance abuse services. Inpatient services for medical acute detoxification are accessed utilizing Blue Shield's preferred and non-preferred (not MHSA) providers.
- 2 If the member's physician provides or orders any covered outpatient or out-of-hospital X-ray, laboratory or pathology services beyond those covered by the Preventive Care Services benefit, those services will only be considered for payment under the First Dollar Services section.
- 3 All covered orthotic, prosthesis and durable medical equipment and services have a combined benefit maximum of \$2,000 per member per calendar year, except those services covered under the Diabetes Care benefit and medically necessary oxygen.
- 4 For a listing of Severe Mental Illnesses including Serious Emotional Disturbances of a Child, and other benefit details, please refer to the COI and Policy.
- 5 Blue Shield has contracted with a specialized health care service plan to act as our Mental Health Services Administrator (MHSA). The MHSA provides mental health and substance abuse services, other than inpatient services for medical acute detoxification, through a separate network of MHSA participating providers. Inpatient medical acute detoxification is a medical benefit provided by Blue Shield Life preferred or non-preferred providers.
- 6 Members have coverage for inpatient benefits of no less than 48 hours following a normal delivery and no less than 96 hours following a delivery by cesarean section, unless the treating physician, in consultation with the mother, decides on an earlier discharge. See the COI for more information.
- 7 The drug formulary is a comprehensive list of recommended drugs, based on safety, efficacy, FDA bioequivalency and cost-effectiveness, and is reviewed and updated four times per year. Always present your Blue Shield ID Card to obtain benefits at a participating (network) pharmacy. Prescription drugs obtained from non-participating pharmacies are not covered. Call (800) 351-2465 to find out if a particular drug is on the Blue Shield drug formulary, or to request a copy of the formulary. For the most current information, you can access the formulary on the Blue Shield Web site at [www.mylifepath.com](http://www.mylifepath.com).
- 8 If a member requests a brand-name drug or the physician states Dispense As Written (DAW), when an equivalent generic drug is available, and the brand-name drug deductible has been satisfied, the member pays the generic copayment plus the cost difference between the brand-name and generic drug. Member pays a copayment of 10% for formulary brand-name drugs. The 10% members' responsibility is calculated by taking Blue Shield's contracted rate, minus the dollar copayment, and then taking 10% of the remaining amount.
- 9 Home self-administered injectables are available through a network of participating pharmacies. They are only covered when obtained from a participating pharmacy, and they require prior authorization from Blue Shield Pharmacy Services.