

# Core Flex Basic<sup>SM</sup>

## Benefit Summary (For groups of 51 and above)

(Uniform Health Plan Benefits and Coverage Matrix)

### Blue Shield of California

Highlights: A description of the prescription drug coverage is provided separately

**THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.**

This plan is part of a package of 5 plans that must be offered together: Core Flex Basic, Core Flex 70/50, Core Flex 80/60, Core Flex 90/70, and Core Flex 90/70 Premier. You should receive a benefit summary to review for each plan. Please note that the rates you pay for yourself and your dependents vary between the plans. Your employer may have purchased an HMO plan in addition to this package. Please check with your employer for details.

Effective July 1, 2010

DEDUCTIBLES	Preferred Providers <sup>1</sup>	Non-Preferred Providers <sup>1</sup>
<b>Calendar year medical deductible</b> (All providers combined) <small>(Note: For individual on family coverage plan, enrollee can receive benefits for covered services once individual deductible is met.)</small>		\$3,000 per individual/ \$6,000 per family
<b>Calendar year out-of-pocket maximum<sup>1</sup></b> (Includes the plan deductible) <small>(Note: For individual on family coverage plan, enrollee can receive 100% benefits for covered services once individual out-of-pocket maximum is met.)</small>	\$5,600 per individual/ \$11,200 per family	\$10,000 per individual/ \$20,000 per family
<b>LIFETIME MAXIMUM</b>	\$6,000,000	
Covered Services	Member Copayment	
PROFESSIONAL SERVICES	Preferred Providers <sup>1</sup>	Non-Preferred Providers <sup>1</sup>
<b>Professional (physician) benefits</b>		
• Physician and specialist office visits	30%	50%
• Outpatient X-ray, pathology and laboratory	30%	50%
<b>Allergy testing and treatment benefits</b>		
• Office visits (includes visits for allergy serum injections)	30%	50%
<b>Preventive care benefits</b>		
• Annual routine physical examination, vision and hearing screening and immunizations	No charge <sup>2</sup>	Not covered
• Routine laboratory services, including annual mammography, Papanicolaou test, or cervical cancer and human papillomavirus (HPV) screening	No charge <sup>2</sup>	Not covered
• Well baby care (Includes: eye/ear screenings, immunizations, vaccinations)	No charge <sup>2</sup>	Not covered
• Well baby laboratory	No charge <sup>2</sup>	Not covered
OUTPATIENT SERVICES		
<b>Hospital benefits (facility services)</b> <small>The maximum allowed charges for non-emergency surgery and services performed in a non-participating Ambulatory Surgery Center or outpatient unit of a non-preferred hospital is \$350 per day. Members are responsible for 50% of this \$350 per day, plus all charges in excess of \$350.</small>		
• Outpatient surgery performed in a Participating Ambulatory Surgery Center (ASC) <sup>3</sup>	30%	50%
• Outpatient surgery in a hospital	30%	50%
• Outpatient services for treatment of illness or injury and necessary supplies (Except as described under "Rehabilitation services")	30%	50%
• Bariatric surgery <sup>5</sup> (pre-authorization required; medically necessary surgery for weight loss, for morbid obesity only)	30%	50%
HOSPITALIZATION SERVICES		
<b>Hospital benefits (facility services)</b>		
• Inpatient physician benefits	30%	50%
• Semi-private room and board, medically necessary services and supplies	30%	50% <sup>4</sup>
• Bariatric surgery <sup>5</sup> (pre-authorization required; medically necessary surgery for weight loss, for morbid obesity only)	30%	50% <sup>4</sup>
<b>Skilled nursing facility benefits<sup>6</sup></b> <small>(Combined maximum of up to 100 preauthorized days per calendar year; semi-private accommodations)</small>		
• Skilled nursing free standing facility	30%	30% with prior authorization <sup>6</sup>
• Skilled nursing facility unit of a hospital	30%	50% <sup>4</sup>

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<b>EMERGENCY HEALTH COVERAGE</b>		
• Emergency room services not resulting in admission (ER Facility copay does not apply if the member is admitted directly from the ER for inpatient services.)	30%	30%
• Emergency room services resulting in admission (when the member is admitted directly from the ER)	30%	30%
• Emergency room physician services	30%	30%
<b>AMBULANCE SERVICES</b>		
• Emergency or authorized transport	30%	30%
<b>PRESCRIPTION DRUG COVERAGE</b> <sup>7, 8, 9, 10, 11, 12, 13</sup>		
(Subject to deductible; includes oral contraceptives, diaphragms, and covered diabetic drugs and testing supplies)		
<b>Outpatient Prescription Drug Benefits</b>	<b>Participating Pharmacy</b>	<b>Non-Participating Pharmacy</b>
<b>Retail prescriptions</b> (For up to a 30-day supply)		
• Formulary generic drugs	\$10 per prescription	25%+\$10 per prescription
• Formulary brand name drugs	\$30 per prescription	25%+\$30 per prescription
• Non-formulary brand name drugs	\$50 per prescription	25%+\$50 per prescription
<b>Mail service prescriptions</b> (For up to a 90-day supply)		
• Formulary generic drugs	\$20 per prescription	Not covered
• Formulary brand name drugs	\$60 per prescription	Not covered
• Non-formulary brand name drugs	\$100 per prescription	Not covered
<b>Specialty Pharmacies</b>		
• Specialty drugs	30% up to \$150 out-of-pocket member copayment max per prescription	Not covered
<b>PROSTHETICS/ORTHOTICS</b>		
• Prosthetic equipment and devices (Separate office visit copay may apply)	30%	50%
• Orthotic equipment and devices (Separate office visit copay may apply)	30%	50%
<b>DURABLE MEDICAL EQUIPMENT</b>		
• Durable medical equipment services (Plan payment up to \$2,000 maximum per calendar year)	30%	50%
<b>MENTAL HEALTH SERVICES (PSYCHIATRIC)<sup>14</sup></b>		
	<b>MHSA Participating Providers<sup>1</sup></b>	<b>MHSA Non-Participating Providers<sup>1</sup></b>
• Inpatient hospital facility services	30%	50% <sup>4</sup>
• Outpatient mental health services	30%	50%
<b>CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)<sup>17</sup></b>		
<b>Please see footnote 15</b>		
• Chemical dependency and substance abuse services	Not Covered	Not Covered
<b>HOME HEALTH SERVICES<sup>18</sup></b>		
	<b>Preferred Providers<sup>1</sup></b>	<b>Non-Preferred Providers<sup>1</sup></b>
• Home health care agency services (Up to 100 prior authorized visit maximum per calendar year)	30%	Not covered <sup>18</sup>
• Home infusion/home injectable therapy provided by a home infusion agency	30%	Not covered <sup>18</sup>
<b>OTHER</b>		
<b>Hospice program benefits<sup>18</sup></b>		
• Routine home care	No charge	Not covered <sup>18</sup>
• Inpatient respite care	No charge	Not covered <sup>18</sup>
• 24 hour continuous home care	30%	Not covered <sup>18</sup>
• General inpatient care	30%	Not covered <sup>18</sup>
<b>Chiropractic benefits<sup>16</sup></b>		
• Chiropractic services – provided by a chiropractor (Up to 20 visits per calendar year)	30%	50%
<b>Acupuncture benefits</b>		
• Acupuncture services	Not covered	Not covered
<b>Rehabilitation services (physical, occupational and respiratory therapy)</b>		
• In an office location	30%	50%
<b>Speech therapy benefits</b>		
• In an office location	30%	50%

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**Pregnancy and maternity care benefits**

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|--|-----|-----|
| • Prenatal and postnatal physician office visits<br>(For inpatient hospital services, see "Hospitalization Services.") | 30% | 50% |
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**Family planning benefits**

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|-----------------------------------|-----|-------------|
| • Counseling and consulting       | 30% | Not covered |
| • Tubal ligation <sup>19</sup>    | 30% | Not covered |
| • Elective abortion <sup>19</sup> | 30% | Not covered |
| • Vasectomy <sup>19</sup>         | 30% | Not covered |

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**Diabetes care benefits**

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|---|-----|-----|
| • Devices, equipment and non-testing supplies<br>(For testing supplies, see "Outpatient Prescription Drug Coverage.")         | 30% | 50% |
| • Diabetes self-management training (If billed by your provider, you will also be responsible for the office visit copayment) | 30% | 50% |

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**Care outside of plan service area** (Benefits provided through the BlueCard® Program) Benefits provided through BlueCard Program, for out-of-state emergency and non-emergency care, are provided at the preferred level of the local Blue Plan allowable amount when you use a Blue Cross/Blue Shield provider.

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|-------------------------------------|------------------------|------------------------|
| • Within US: BlueCard Program       | See Applicable Benefit | See Applicable Benefit |
| • Outside of US: BlueCard Worldwide | See Applicable Benefit | See Applicable Benefit |

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**Optional Benefits**

Optional dental, vision, substance abuse treatment or infertility benefits are available. If your employer purchased any of these benefits, a description of the benefit is provided separately.

- Member is responsible for copayment in addition to any charges above allowable amounts. The copayment 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 in excess of the allowable amount do not count toward the calendar-year deductible or out-of-pocket maximum. Payments applied to your Calendar Year Deductible accrue towards the Maximum Calendar Year Out-of-Pocket Responsibility.
- The preventive care and well-baby care office visit are not subject to the plan deductible. Other covered non-preventive services received during or in connection with the office visit are subject to the plan deductible and the applicable copayment percentage.
- Participating ambulatory surgery centers may not be available in all areas. Regardless of their availability, you can obtain outpatient surgery services from a hospital or an ambulatory surgery center affiliated with a hospital, with payment according to your health plan's hospital services benefits.
- The maximum allowed charge for non-emergency hospital services received from a non-preferred hospital is \$600 per day. Members are responsible for 50 percent of this \$600 per day, plus all charges in excess of \$600. Payments that exceed the allowed charge do not count toward the calendar-year out-of-pocket maximum, and continue to be charged after it is reached.
- Bariatric surgery is covered when pre-authorized by Blue Shield. However, for members residing in Imperial, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Barbara and Ventura Counties ("Designated Counties"), bariatric surgery services are covered only when performed at designated contracting bariatric surgery facilities and by designated contracting surgeons; coverage is not available for bariatric services from any other preferred provider and there is no coverage for bariatric services from non-preferred Providers. In addition, if prior authorized by Blue Shield of California, a member in a Designated County who is required to travel more than 50 miles to a designated bariatric surgery facility will be eligible for limited reimbursement for specified travel expenses for the member and one companion. Refer to the Evidence of Coverage for further benefit details.
- Services may require prior authorization by Blue Shield. When services are prior authorized, members pay the preferred or participating provider amount.
- This plan's prescription drug coverage provides, on average, less coverage than the standard benefit set by the federal government for Medicare Part D (also called "non-creditable" coverage). It is important to know that you may only enroll in a Medicare Part D plan during specified times of the year, and if you do not enroll when first eligible you may be subject to payment of higher Medicare Part D premiums when you enroll at a later date. For more information about drug coverage, call the customer service number on your member ID card, Monday through Thursday, 8:00am - 5:00pm or Friday, 9:00am - 5:00pm. The hearing impaired may call the TTY number also listed on your member ID card. 8 If the member requests a Brand Name Drug when a Generic Drug equivalent is available, the member is responsible for paying the difference between the cost to Blue Shield of the Brand Name Drug and its Generic Drug equivalent, as well as the applicable Generic Drug Copayment. This difference in cost that the member must pay is not applied to the Calendar Year Deductible and is not included in the Calendar Year maximum out-of-pocket responsibility calculations.
- Please note that if you switch from another plan, your prescription drug deductible credit from the previous plan during the calendar year, if applicable, will not carry forward to your new plan.
- For the Outpatient Drugs benefit, covered drugs obtained from Non-Participating Pharmacies will be subject to and accrue to the deductible and the copay maximum for Preferred Providers.
- Specialty drugs are covered only when dispensed by select pharmacies in the Specialty Pharmacy Network unless Medically Necessary for a covered emergency.
- Selected formulary and non-formulary drugs require prior authorization by Blue Shield for Medical Necessity, and when effective, lower cost alternatives are available.
- Specialty Drugs are specific Drugs used to treat complex or chronic conditions which usually require close monitoring such as multiple sclerosis, hepatitis, rheumatoid arthritis, cancers, and other conditions that are difficult to treat with traditional therapies. Specialty Drugs are listed in the Blue Shield Outpatient Drug Formulary. Specialty Drugs may be self-administered in the home by injection by the patient or family member (subcutaneously or intramuscularly), by inhalation, orally or topically. Infused or Intravenous (IV) medications are not included as Specialty Drugs. These Drugs may also require special handling, special manufacturing processes, and may have limited prescribing or limited pharmacy availability. Specialty Drugs must be considered safe for self-administration by Blue Shield's Pharmacy & Therapeutics Committee, be obtained from a Blue Shield Specialty Pharmacy and may require prior authorization for Medical Necessity by Blue Shield
- Mental health services are accessed through Blue Shield's Mental Health Service Administrator (MHSA) - using Blue Shield's MHSA participating and non-participating providers. Only Blue Shield MHSA contracted providers are administered by the Blue Shield MHSA. Behavioral health services rendered by non participating providers are administered by Blue Shield. 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.
- 15 Optional substance abuse treatment benefits are available. If your employer purchased these benefits, a description of the benefit is attached hereto as "Additional Substance Abuse Treatment Benefits."**
- Chiropractic visits accrue to the calendar-year visit maximum regardless of whether the plan deductible has been met.
- Inpatient services for acute detoxification are covered under the medical benefit; see hospitalization services for benefit details. Services for medical acute detoxification are accessed through Blue Shield using Blue Shield's preferred providers or non-preferred providers.
- Out of network home health care, home infusion and hospice services are not covered unless pre-authorized. When these services are pre-authorized, the member pays the Preferred Provider copayment.
- Copayment shown is for physician's services. If the procedure is performed in a facility setting (hospital or outpatient surgery center), an additional facility copayment may apply.