



# Active Start Plan 35

## 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.

ACTIVE START PLAN 35	
This plan is underwritten by Blue Shield of California Life & Health Insurance Company.	
DEDUCTIBLE*	\$0
COPAYMENTS	\$35 with Preferred Providers Not applicable with Non-Preferred Providers
PERCENTAGE COPAYMENTS	40% with Preferred Choice Hospitals 45% with Preferred Affiliate Hospitals 50% with Non-Preferred Providers
CALENDAR-YEAR COPAYMENT/COINSURANCE MAXIMUM (Some services do not apply.)	Services with Preferred Choice Providers**: \$7,500 Individual only Services with All Providers: \$10,000
LIFETIME MAXIMUM	\$6,000,000
* Benefits for covered brand-name drugs are subject to a \$750 brand-name drug deductible per person. ** This copayment/coinsurance maximum also includes copayments from preferred providers when there is no designation of "Choice Hospitals" or "Affiliate Hospitals."	

COVERED SERVICES	MEMBER COPAYMENTS	
	With Preferred Providers, <sup>1</sup> you pay	With Non-Preferred Providers, <sup>1</sup> you pay
<b>PROFESSIONAL SERVICES</b>		
– Office visits, consultations, OB/GYN and specialist visits, second surgical opinions, urgent care services, asthma self-management training	\$35	50%
– Allergy testing and treatment	40%	50%
<b>PREVENTIVE CARE</b>		
– Annual Routine Physical Exam, Well-Baby care office visits, and Gynecological exam office visit (includes Pap test or other approved cervical cancer screening tests, routine mammography, and immunizations when received as part of the annual exam or preventive care visit)	\$35	Not Covered
<b>OUTPATIENT SERVICES</b>		
– Non-Emergency services and procedures	40% w/Choice Hospitals	45% w/Affiliate Hospitals
– Outpatient surgery in hospital	\$500/admit + 40% w/Choice Hospitals	\$500/admit + 45% w/Affiliate Hospitals
– Outpatient or Out-of-Hospital X-ray and Laboratory	40%	50%
– Non-Emergency surgery in an Ambulatory Surgery Center (ASC)	40%	50% <sup>2,3</sup>
– Radiological Procedure requiring prior authorization (such as CT scans, MRIs, MRAs, PET scans, Bone Densitometry and any cardiac diagnostic procedure utilizing Nuclear Medicine)	40%	50%

**COVERED SERVICES**

**MEMBER COPAYMENTS**

With Preferred Providers,<sup>1</sup> you pay

With Non-Preferred Providers,<sup>1</sup> you pay

**HOSPITALIZATION SERVICES**

– Inpatient physician visits and consultations, surgeons and assistants, and anesthesiologists	40%	50%
– Inpatient semiprivate room and board, services and supplies and subacute care	\$500/admit + 40% w/Choice Hospitals	\$500/admit + 45% w/Affiliate Hospitals
		50% <sup>2,3</sup>

**EMERGENCY HEALTH COVERAGE**

– Outpatient Emergency room facility services, semiprivate room and board, services and supplies, and subacute care not resulting in admission (\$30 copayment waived if the member is admitted directly to the hospital as an inpatient)	\$30/visit + 40%	\$30/visit + 40%
– ER Physician visits <sup>4</sup>	\$35	\$35

**AMBULANCE SERVICES** (Surface or Air)<sup>5</sup>

40%

40%

**PRESCRIPTION DRUG COVERAGE<sup>6</sup>**

(outpatient; brand-name drugs are subject to a \$750 brand-name drug deductible per person, per calendar year; includes oral contraceptives, diaphragms, diabetic testing supplies, and asthma inhalers and inhaler spacers)

**At Participating Pharmacies**  
(Up to a 30-day supply)

**Mail Service Prescriptions**  
(Up to a 60-day supply)

– Generic formulary drugs	\$8/prescription <sup>2</sup>	\$16/prescription <sup>2</sup>
– Formulary brand-name drugs <sup>†,7</sup>	\$35/prescription <sup>2</sup>	\$70/prescription <sup>2</sup>
– Non-formulary brand-name drugs <sup>†,7</sup>	\$50 or 50%/prescription (whichever is greater) <sup>2</sup>	\$100 or 50%/prescription (whichever is greater) <sup>2</sup>
– Home Self-Administered Injectables <sup>8</sup>	30% <sup>2</sup>	Not Covered

**DURABLE MEDICAL EQUIPMENT**

– Prosthetic Appliances, Home Medical Equipment, Asthma Nebulizers (including face masks and tubing), Peak Flow Monitors and Orthotic Equipment <sup>9</sup>	40%	50%
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With MHSA Participating Providers,<sup>1</sup> you pay

With MHSA Non-Participating Providers,<sup>1</sup> you pay

**MENTAL HEALTH SERVICES<sup>10,11</sup>**

– Inpatient Hospital Facility Services	\$500/admit + 40%	50% <sup>2,3</sup>
– Inpatient Physician Services	40%	50%
– Outpatient visits for severe mental health conditions	\$35	50%
– Outpatient visits for non-severe mental health conditions (up to 20 visits per calendar year combined with chemical dependency visits)	40% <sup>2</sup>	Not Covered

**CHEMICAL DEPENDENCY SERVICES**

(Substance Abuse)<sup>11</sup>

– Inpatient Hospital Facility Services for medical acute detoxification	\$500/admit + 40% w/Choice Hospitals	\$500/admit + 45% w/Affiliate Hospitals	50% <sup>2,3</sup>
– Inpatient Physician Services for medical acute detoxification	40%		50%
– Outpatient visits (up to 20 visits per calendar year combined with non-severe mental health visits)	40% <sup>2</sup>		Not Covered

With Preferred Providers,<sup>1</sup> you pay

With Non-Preferred Providers,<sup>1</sup> you pay

**HOME HEALTH SERVICES**

(up to 90 preauthorized visits per calendar year)

40%

Not Covered

**COVERED SERVICES**

**MEMBER COPAYMENTS**

With Preferred Providers,<sup>1</sup> you pay

With Non-Preferred Providers,<sup>1</sup> you pay

**OTHER**

**Pregnancy and Maternity Care**

– Outpatient prenatal and postnatal care	Not Covered	Not Covered
– Delivery and all necessary inpatient hospital services	Not Covered	Not Covered

**Family Planning**

– Consultations, tubal ligation, vasectomy, elective abortion	40%	Not Covered
– Injectable Contraceptives <sup>12</sup>	\$25 <sup>2</sup>	Not Covered

**Rehabilitation Services**

(up to 12 visits per calendar year combined with Chiropractic and Speech Therapy visits)

– Physical, occupational, or respiratory therapy received in a physician’s office or outpatient department of a hospital	40%	50% (up to a maximum payment of \$25/visit)
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**Chiropractic Services**

(up to 12 visits per calendar year combined with Rehabilitation Services and Speech Therapy visits)

– Received from a chiropractor	40%	50% (up to a maximum payment of \$25/visit)
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**Skilled Nursing Facility (SNF) and Subacute Care**

(semiprivate accommodations following transfer from hospital unless Blue Shield gives written authorization; up to 100 days per calendar year)

40% in hospital or freestanding SNF

50%<sup>2</sup> in hospital  
40% in freestanding SNF

**Out-of-State Services**

(full plan benefits covered nationwide with the BlueCard program)

40% with BlueCard Participating Providers

50% with all other providers

**Diabetes Care**

– Diabetes Self-Management Training	\$35	50% <sup>2</sup>
– Diabetes Care Supplies	40%	50%

**Dental Services and Life Insurance (Optional dental benefits and life insurance are available.)**

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

‡ The brand-name drug deductible is separate from the medical plan deductible.

- 1 Member is responsible for 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 allowable amounts as payment-in-full for covered services. Non-preferred providers can charge more than these amounts. When members use non-preferred providers, they must pay the applicable copayment or coinsurance plus any charges that exceed Blue Shield’s allowable amount. Charges above the allowable amount do not count toward the copayment/coinsurance maximum. Mental health and chemical dependency 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, 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 through Blue Shield utilizing Blue Shield’s preferred and non-preferred (not MHSA) providers.
- 2 These copayments do not count toward the copayment/coinsurance maximum and will continue to be charged once the copayment/coinsurance maximum is reached.
- 3 For non-emergency hospital services and supplies received from a non-preferred hospital, Blue Shield’s payment is limited to \$250 per day. Members are responsible for all charges that exceed \$250 per day.
- 4 Members pay the preferred provider copayment, \$35 per visit, for physician services received during an emergency room visit.
- 5 Members who reasonably believe that they have an emergency medical condition which requires an emergency response are encouraged to appropriately use the 911 emergency response system where available.
- 6 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. Except for covered emergencies, 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 [mylifepath.com](http://mylifepath.com).
- 7 If a member requests a brand-name drug or the physician indicates Dispense As Written (DAW) for a prescription, when an equivalent generic drug is available, and the brand-name drug deductible has been satisfied, the member pays the generic copayment plus the difference between the brand and generic drug cost.
- 8 Home self-administered injectables are available through pharmacies designated in a specialty network. They are only covered when obtained from a pharmacy designated in a specialty network, and they require prior authorization from Blue Shield Pharmacy Services.
- 9 All covered home medical, orthoses and prostheses equipment and services have a benefit maximum of \$2,000 per member per calendar year, except those services covered under the Diabetes Care benefit and medically necessary oxygen.
- 10 For a listing of Severe Mental Illnesses including Serious Emotional Disturbances of a Child and other benefit details, please refer to the *Certificate of Insurance (COI)*.
- 11 Blue Shield has contracted with a specialized healthcare service plan to act as our mental health services administrator (MHSA). The MHSA provides mental health and chemical dependency 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 preferred or non-preferred (not MHSA) providers.
- 12 Member is responsible for the office visit copayment in addition to the \$25 copayment.