

Alhambra Unified School District

Group #977716

Custom Shield Spectrum PPOSM 100/70

Benefit Summary (For groups of 300 and above)
(Uniform Health Plan Benefits and Coverage Matrix)

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

Blue Shield of California

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

Effective October 1, 2010

DEDUCTIBLES (All providers combined)	Preferred Providers¹	Non-Preferred Providers¹
Calendar- year medical deductible	\$250 per individual \$750 per family	
Calendar- year Copayment Maximum	\$0 per individual \$0 per family	\$600 per member in California \$400 per member outside California
LIFETIME MAXIMUM	None	
Covered Services	Member Copayment	
Preventive Benefits – deductible waived	Preferred Providers	Non-Preferred Providers
Physician Services		
• Annual routine Physical Office visit (one per calendar year, 17 years of age and older)	No charge	30%
• Annual Pap test & Mammography for screening and diagnostic purposes	No charge	30%
• Laboratory, X-rays, diagnostics, immunizations and vaccinations; tuberculin tests	No charge	30%
• Sigmoidoscopy for screening and diagnostic purposes (beginning at age 50; once every 5 years)	No charge	30%
• Eye and ear screenings (through age 16)	No charge	30%
• Venereal disease tests	No charge	30%
• Blood lead level testing for all dependent children	No charge	30%
Physician Services - Outpatient		
• Office visits and consultations	No charge	30%
• Specialist visits and consultations	No charge	30%
• Laboratory, x-rays and diagnostics	No charge	30%
Physician Services - Inpatient		
• Inpatient visits and consultations	No charge	30%
• Surgeons and assistants, anesthesiologists, pathologist, radiologist	No charge	30%
Hospital services - Outpatient		
• Outpatient surgery	No charge	30%
• Renal Dialysis	No charge	30%
Hospital services - Inpatient		
• Semi-private room and board, medically necessary services and supplies including subacute care	No charge	30%
Well Child care (from birth through age 16)		
• Office visits and consultations including eye and ear screening	No charge	30%
• Laboratory, diagnostics and other services	No charge	30%
• Immunizations, tuberculin tests	No charge	30%
Pregnancy and Maternity Care		
• Prenatal and postnatal care	No charge	30%
• All medically necessary inpatient hospital services	No charge	30%
• Routine circumcision	No charge	30%
Family Planning		
• Family planning counseling	No charge	30%
• Elective abortion	No charge	30%
• Tubal ligation, vasectomy	No charge	30%

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Skilled Nursing Facility (SNF) Services		
• Semi-private accommodations in a Freestanding SNF	No charge	30%
• Semi-private accommodations in a Hospital SNF	No charge	30%
Home Health and Home Hospice Services		
• Home infusion services / Home injectables therapy (includes PKU formulas and special foods; authorization is required)	No charge	30%
• Home Health/Home Hospice	No charge	30%
• Facility Hospice care (prior authorization required)	No charge	30%
Physical Medicine		
• Office visits and related services (such as physical therapy, occupational therapy)	No charge	30%
• Speech therapy	No charge	30%
• Chiropractic Services (\$4,000 benefit maximum per person per calendar year)	No charge	30%
• Acupuncture Services (\$250 per person per calendar year when rendered by an M.D. or certified Acupuncturist.	No charge	30%
Mental Health Services (Psychiatric)		
• Inpatient hospital facility care for mental health conditions	No charge	30%
• Outpatient visits for mental health conditions	No charge	30%
Chemical Dependency (Substance Abuse)		
• Inpatient hospital chemical dependency care	No charge	30%
• Outpatient visits for chemical dependency	No charge	30%
OTHER		
• Prosthetics and Orthotics (equipment and devices only)	No charge	30%
• Durable Medical Equipment	No charge	30%
• Emergency Services (copayment waived if admitted to hospital)	\$100/visit	\$100/visit
• Ambulance Services (includes ground and air transport)	No charge	30%
• Annual eye refraction in preparation for glasses	No charge	30%
Christian Science		
• Practitioner (limited to 70 visits per calendar year; 1 visit per day)		\$25/visit
• Nursing services (limited to 70 visits per calendar year; 1 visit per day)		\$20/visit
• Sanatorium Services (limited to 70 visits per calendar year)		No charge
Diabetes care		
• Equipment, devices and non-testing supplies (For testing supplies, see "Prescription Drug Coverage.")	No charge	30%
Diabetes Self-Management Education	For persons enrolled in a diabetic day care self-management education program, benefits are provided for the charges of a day care center for diabetes self-management education; and the Services of a Physician or other professional who is knowledgeable about the treatment of diabetes provided that the charges for such Services do not duplicate those charged by the day care center. Diabetic day care is limited to four day care days during a consecutive 24-month period.	
Hearing Aids	Payable at 80%, subject to plan deductible, up to a maximum of \$2,500 per device every 36 months, including hearing exam. Covers one device for each ear in a 36-month period. If both devices are not purchased at the same time, the 2 nd device will be suspended for review to determine that it is not for the same ear.	
Covered out-of-state services; Benefits provided through BlueCard [®] Program, except for certain Mental Health and Substance Abuse benefits, for out-of-state emergency and non-emergency care, are provided at the preferred level of the local Blue Plan allowable when you use a Blue Cross/Blue Shield provider.		
	No charge	30%

1. 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 for services which are not covered, and charges by non-Preferred Providers in excess of the amount covered by the Plan, such as Physician charges above the Allowable Amount, are the Participant's responsibility, and are not included in the maximum Calendar Year copayment responsibility calculations, and may cause a Participant's payment responsibility to exceed the maximum copayment amount.

Blue Shield believes this plan/policy is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan or policy is not required to include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Note, even though they are not required to be included, many of the protections of the Affordable Care Act are included in your current plan/policy.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Blue Shield at the telephone number on your identification card. If you obtain this plan/policy through your employer and your plan is subject to ERISA, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans. If you obtain your coverage through a nonfederal governmental employer, you may also contact the U.S. Department of Health and Human Services at www.healthreform.gov