blue of california

Pending Regulatory Approval

# City of Los Angeles Custom Shield Spectrum PPO

**Coverage Period: 01/01/2015-12/31/2015**

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs **Coverage for:** Individual + Family | **Plan Type:** PPO

**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.blueshieldca.com/lacity or by calling **1-855-201-2086; TTY 1-800-241-1823**.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | For participating providers: **$750** per individual / **$1,500** per family. For non-participating providers: **$1,250** per individual / **$2,500** per family. Does not apply to emergency room facility services not resulting in admission**,** participating physician and specialist office visits**,** breast pump**,** preventive health services at participating providers, and outpatient prescription drug benefits. | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| **Is there an out–of–pocket limit on my expenses?** | Yes. **$2,000** per individual / **$4,000** per family. | The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| **What is not included in the out–of–pocket limit?** | Premiums, balance-billed charges, some copayments, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. |
| **Is there an overall annual limit on what the plan pays?** | No. | The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits. |
| **Does this plan use a network of providers?** | Yes. See www.blueshieldca.com/lacity or | If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, |

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| | **call 1-855-201-2086; TTY 1-800-241-1823** for a list of participating providers. | **preferred**, or participating for **providers** in their **network.** See the chart starting on page 2 for how this plan pays different kinds of **providers**. |
| **Do I need a referral to see a specialist?** | No. | You can see the **specialist** you choose without permission from this plan. |
| **Are there services this plan doesn't cover?** | Yes. | Some of the services this plan doesn't cover are listed on page 11. See your policy or plan document for additional information about **excluded services**. |

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

| Common Medical Event | Services You May Need | Your Cost If You Use a Participating Provider | Your Cost If You Use a Non-Participating Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $30 copayment / visit | 30% coinsurance | No charge for children under age 6.<br>For other services received during the office visit, additional member cost-share may apply.<br>Not subject to the calendar-year medical deductible at participating providers. |

| Common Medical Event | Services You May Need | Your Cost If You Use a Participating Provider | Your Cost If You Use a Non-Participating Provider | Limitations & Exceptions |
|---|---|---|---|---|
| | Specialist visit | $30 copayment / visit | 30% coinsurance | No charge for children under age 6. For other services received during the office visit, additional member cost-share may apply.<br>Not subject to the calendar-year medical deductible at participating providers. |
| | Other practitioner office visit | <u>Chiropractic:</u><br>10% coinsurance<br><br><u>Acupuncture:</u><br>10% coinsurance | <u>Chiropractic:</u><br>30% coinsurance<br><br><u>Acupuncture:</u><br>10% coinsurance | Coverage for chiropractic services is limited to 24 visits per calendar year.<br><br>Coverage for acupuncture services is limited to 20 visits per calendar year.<br><br>Additional member cost-share applies for covered X-ray services received in conjunction with the office visit. |
| | Preventive care/screening /immunization | No Charge | 30% coinsurance | Coverage for services consistent with ACA requirements and California laws. Please refer to your plan contract for details.<br>Not subject to the calendar-year medical deductible at participating providers. |



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| Common Medical Event | Services You May Need | Your Cost If You Use a Participating Provider | Your Cost If You Use a Non-Participating Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you have a test** | Diagnostic test (x-ray, blood work) | Lab & Path at Free Standing Location:<br>10% coinsurance<br><br>X-Ray & Imaging at Free Standing Radiology Center:<br>10% coinsurance<br><br>Other Diagnostic Examination at Free Standing Location:<br>10% coinsurance<br><br>X-Ray, Lab & Other Examination at Outpatient Hospital:<br>10% coinsurance | Lab & Path at Free Standing Location:<br>30% coinsurance<br><br>X-Ray & Imaging at Free Standing Radiology Center:<br>30% coinsurance<br><br>Other Diagnostic Examination at Free Standing Location:<br>30% coinsurance<br><br>X-Ray, Lab & Other Examination at Outpatient Hospital:<br>30% coinsurance | Benefits in this section are for diagnostic, non-preventive health services.<br><br>X-Ray, Lab & Other Examination at Outpatient Hospital:<br>The maximum allowed amount for non-participating providers is $350 per day. Members are responsible for 30% of this $350 per day, plus all charges in excess of $350. |
| | Imaging (CT/PET scans, MRIs) | Radiological & Nuclear Imaging at Free Standing Radiology Center:<br>10% coinsurance<br><br>Radiological & Nuclear Imaging at Outpatient Hospital:<br>10% coinsurance | Radiological & Nuclear Imaging at Free Standing Radiology Center:<br>30% coinsurance<br><br>Radiological & Nuclear Imaging at Outpatient Hospital:<br>30% coinsurance | Benefits in this section are for diagnostic, non-preventive health services.<br>Pre-authorization is required.<br>Radiological & Nuclear Imaging at Outpatient Hospital:<br>The maximum allowed amount for non-participating providers is $350 per day. Members are responsible for 30% of this $350 per day, plus all charges in excess of $350. |

| Common Medical Event | Services You May Need | Your Cost If You Use a Participating Provider | Your Cost If You Use a Non-Participating Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.blueshieldca.com/lacity | Generic drugs | Retail:<br>$10 copayment / prescription<br>Mail Order:<br>$20 copayment / prescription | Retail:<br>25% of billed amount + $10 copayment / prescription<br>Mail Order:<br>Not Covered | Retail: Covers up to a 30-day supply;<br><br>Mail Order: Covers up to a 90-day supply.<br><br>Select formulary and non-formulary drugs require pre-authorization. |
| | Brand Formulary Drugs | Retail:<br>$20 copayment / prescription<br>Mail Order:<br>$40 copayment / prescription | Retail:<br>25% of billed amount + $20 copayment / prescription<br>Mail Order:<br>Not Covered | |
| | Brand Non-Formulary Drugs | Retail:<br>$40 copayment / prescription<br>Mail Order:<br>$80 copayment / prescription | Retail:<br>25% of billed amount + $40 copayment / prescription<br>Mail Order:<br>Not Covered | |
| | Specialty drugs | Applicable Retail Drug Copayment Applies | Not Covered | Covers up to a 30-day supply. Coverage limited to drugs dispensed by select pharmacies in the Specialty Pharmacy Network unless medically necessary for a covered emergency. Pre-authorization is required. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance | 30% coinsurance | The maximum allowed amount for non-participating providers is $350 per day. Members are responsible for 30% of this $350 per day, plus all charges in excess of $350. |
| | Physician/surgeon fees | 10% coinsurance | 30% coinsurance | -------------------None------------------- |



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| Common Medical Event | Services You May Need | Your Cost If You Use a Participating Provider | Your Cost If You Use a Non-Participating Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need immediate medical attention** | Emergency room services | $100 copayment / visit + 10% coinsurance | $100 copayment / visit + 10% coinsurance | Copayment waived if admitted; standard inpatient hospital facility benefits apply.<br>Not subject to the calendar-year medical deductible.<br>This is for the hospital/facility charge only. The ER physician charge is separate.<br>Coverage outside of California under BlueCard. |
| | Emergency medical transportation | 10% coinsurance | 10% coinsurance | -------------------None------------------- |
| | Urgent care | $30 copayment / visit at freestanding urgent care center | 30% coinsurance at freestanding urgent care center | No charge for children under age 6. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 10% coinsurance | 30% coinsurance | The maximum allowed amount for non-participating providers is $1,500 per day. Members are responsible for 30% of this $1,500 per day, plus all charges in excess of $1,500.<br>Pre-authorization is required for all services.<br>Failure to obtain pre-authorization for special transplant services may result in non-payment of benefits. |
| | Physician/surgeon fee | 10% coinsurance | 30% coinsurance | -------------------None------------------- |



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| Common Medical Event | Services You May Need | Your Cost If You Use a Participating Provider | Your Cost If You Use a Non-Participating Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | Mental Health Routine Outpatient Services:<br>$30 copayment / visit<br><br>Mental Health Non-Routine Outpatient Services:<br>$30 copayment / visit | Mental Health Routine Outpatient Services:<br>30% coinsurance<br><br>Mental Health Non-Routine Outpatient Services:<br>30% coinsurance | No charge for children under age 6.<br>Mental Health Routine Outpatient Services:<br>Services include professional/physician office visits.<br>Not subject to the calendar-year medical deductible at participating providers.<br>Mental Health Non-Routine Outpatient Services:<br>Services include behavioral health treatment, electroconvulsive therapy, intensive outpatient programs, partial hospitalization programs, and transcranial magnetic simulation.<br>Higher copayment and facility charges per episode of care may apply for partial hospitalization programs.<br>Pre-authorization from Mental Health Service Administrator (MHSA) is required for non-routine outpatient mental health services. |

| Common Medical Event | Services You May Need | Your Cost If You Use a Participating Provider | Your Cost If You Use a Non-Participating Provider | Limitations & Exceptions |
|---|---|---|---|---|
| | Mental/Behavioral health inpatient services | Mental Health Inpatient Hospital Services:<br>10% coinsurance<br><br>Mental Health Residential Services:<br>10% coinsurance<br><br>Mental Health Inpatient Physician Services:<br>10% coinsurance | Mental Health Inpatient Hospital Services:<br>30% coinsurance<br><br>Mental Health Residential Services:<br>30% coinsurance<br><br>Mental Health Inpatient Physician Services:<br>30% coinsurance | The maximum allowed amount for non-participating providers is $1,500 per day. Members are responsible for 30% of this $1,500 per day, plus all charges in excess of $1,500.<br><br>Pre-authorization from Mental Health Service Administrator (MHSA) is required. |
| | Substance use disorder outpatient services | Substance Abuse Routine Outpatient Services:<br>$30 copayment / visit<br><br>Substance Abuse Non-Routine Outpatient Services:<br>$30 copayment / visit | Substance Abuse Routine Outpatient Services:<br>30% coinsurance<br><br>Substance Abuse Non-Routine Outpatient Services:<br>30% coinsurance | No charge for children under age 6.<br>Substance Abuse Routine Outpatient Services:<br>Services include professional/physician office visits. Not subject to the calendar-year medical deductible at participating providers.<br>Substance Abuse Non-Routine Outpatient Services:<br>Services include partial hospitalization program, intensive outpatient program, and office-based opioid treatment. Higher copayment and facility charges per episode of care may apply for partial hospitalization programs.<br>Pre-authorization from Mental Health Service Administrator (MHSA) is required for non-routine outpatient substance abuse services. |

| Common Medical Event | Services You May Need | Your Cost If You Use a Participating Provider | Your Cost If You Use a Non-Participating Provider | Limitations & Exceptions |
|---|---|---|---|---|
| | Substance use disorder inpatient services | Substance Abuse Inpatient Hospital Services:<br>10% coinsurance<br><br>Substance Abuse Residential Services:<br>10% coinsurance<br><br>Substance Abuse Inpatient Physician Services:<br>10% coinsurance | Substance Abuse Inpatient Hospital Services:<br>30% coinsurance<br><br>Substance Abuse Residential Services:<br>30% coinsurance<br><br>Substance Abuse Inpatient Physician Services:<br>30% coinsurance | The maximum allowed amount for non-participating providers is $1,500 per day. Members are responsible for 30% of this $1,500 per day, plus all charges in excess of $1,500.<br><br>Pre-authorization from Mental Health Service Administrator (MHSA) is required. |
| **If you are pregnant** | Prenatal and postnatal care | Prenatal:<br>$30 copayment / visit<br>Postnatal:<br>$30 copayment / visit | 30% coinsurance | Not subject to the calendar-year medical deductible at participating providers. |
| | Delivery and all inpatient services | 10% coinsurance | 30% coinsurance | The maximum allowed amount for non-participating providers is $1,500 per day. Members are responsible for 30% of this $1,500 per day, plus all charges in excess of $1,500. |

| Common Medical Event | Services You May Need | Your Cost If You Use a Participating Provider | Your Cost If You Use a Non-Participating Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need help recovering or have other special health needs** | Home health care | 10% coinsurance | 10% coinsurance | Coverage limited to 100 visits per member per calendar year. Non-participating home health care and home infusion are not covered unless pre-authorized. When these services are pre-authorized, you pay the participating provider copayment.<br>Pre-authorization is required. |
| | Rehabilitation services | Office visit:<br>10% coinsurance<br><br>Outpatient hospital:<br>10% coinsurance | Office visit:<br>30% coinsurance<br><br>Outpatient hospital:<br>30% coinsurance | Coverage for physical, occupational and respiratory therapy services.<br><br>Outpatient hospital:<br>The maximum allowed amount for non-participating providers is $350 per day. Members are responsible for 30% of this $350 per day, plus all charges in excess of $350. |
| | Habilitation services | Office visit:<br>10% coinsurance<br><br>Outpatient hospital:<br>10% coinsurance | Office visit:<br>30% coinsurance<br><br>Outpatient hospital:<br>30% coinsurance | |
| | Skilled nursing care | 10% coinsurance at freestanding skilled nursing facility | 10% coinsurance at freestanding skilled nursing facility | Coverage limited to 100 days per member per calendar year combined with hospital/free-standing skilled nursing facility.<br>Pre-authorization is required. |
| | Durable medical equipment | 10% coinsurance | 30% coinsurance | Pre-authorization is required. |



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|---|---|---|---|---|
| | Hospice service | No Charge | No Charge | All Hospice Program Benefits must be pre-authorized by the Plan. (With the exception of Pre-hospice consultation.)<br>Failure to obtain pre-authorization may result in non-payment of benefits.<br>10% coinsurance applies for 24-hour continuous home care and general inpatient care hospice services. |
| **If your child needs dental or eye care** | Eye exam | Covered by Blue Shield Vision Plan | Covered by Blue Shield Vision Plan | Please refer to Vision plan documents for further details. |
| | Glasses | Covered by Blue Shield Vision Plan | Covered by Blue Shield Vision Plan | Please refer to Vision plan documents for further details. |
| | Dental check-up | Not Covered | Not Covered | --------------------None------------------ |

## Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery
- Long-term care
- Routine foot care (unless for treatment of diabetes)
- Dental care (Adult/Child)
- Non-emergency care when traveling outside the U.S.
- Weight loss programs
- Infertility treatment
- Private -duty nursing (unless enrolled in a participating hospice program)



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| **Other Covered Services** **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)** | | |
|---|---|---|
| • Acupuncture (coverage limited to 20 visits per calendar year.) | • Chiropractic care (coverage limited to 24 visits per calendar year.) | • Routine eye care (Adult/Child) (Covered by Blue Shield Vision Plan.) |
| • Bariatric surgery (pre-authorization is required. Failure to obtain pre-authorization may result in non-payment of benefits.) | • Hearing aids (coverage limited to $2,000 per member every 24 months.) | |

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at **1-855-201-2086; TTY 1-800-241-1823**. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at **1-866-444-3272** or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at **1-877-267-2323** X **61565** or www.cciio.cms.gov.

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: **1-855-201-2086; TTY 1-800-241-1823** or the Department of Labor's Employee Benefits Security Administration at **1-866-444-EBSA (3272)** or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your **appeal**. Contact California Department of Managed Health Care Help at **1-888-466-2219** or visit http://www.healthhelp.ca.gov.

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**



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## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-346-7198.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-346-7198.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-866-346-7198.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-346-7198.

*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

# About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

## Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,110
- **Patient pays** $1,430

**Sample care costs:**

| | |
|---|---|
| Hospital charges (mother) | $2,700 |
| Routine obstetric care | $2,100 |
| Hospital charges (baby) | $900 |
| Anesthesia | $900 |
| Laboratory tests | $500 |
| Prescriptions | $200 |
| Radiology | $200 |
| Vaccines, other preventive | $40 |
| **Total** | **$7,540** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $750 |
| Copays | $20 |
| Coinsurance | $510 |
| Limits or exclusions | $150 |
| **Total** | **$1,430** |

## Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,880
- **Patient pays** $1,520

**Sample care costs:**

| | |
|---|---|
| Prescriptions | $2,900 |
| Medical Equipment and Supplies | $1,300 |
| Office Visits and Procedures | $700 |
| Education | $300 |
| Laboratory tests | $100 |
| Vaccines, other preventive | $100 |
| **Total** | **$5,400** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $750 |
| Copays | $580 |
| Coinsurance | $110 |
| Limits or exclusions | $80 |
| **Total** | **$1,520** |

# Questions and answers about the Coverage Examples:

## What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.
- Plan and patient payments are based on a single person enrolled on the plan or policy.

## What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

## Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

## Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

## Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

## Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.



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