



Blue Cross POSSM 51-125 KS8 (ZF5B)

For HMO, all services must be authorized by the primary care physician (PCP) and/or the medical group, except services provided under the "ReadyAccess" program, OB/GYN services received within the member's medical group/IPA, and services for all mental disorders. PPO & non-PPO benefits will not be paid for services provided by the member's PCP, or for ReadyAccess program services provided by a physician who works with the member's medical group.

For PPO & non-PPO, in addition to the per member copays, there may be a deductible. Please review the deductible information below to know if a deductible applies to a specific covered service. Regardless from whom they receive services, members are also responsible for all costs over the plan maximums. Plan maximums & other important information appear in *italics*. Benefits are subject to all terms, conditions, limitations, and exclusions of the Policy.

Explanation of Covered Expense

HMO—Charges incurred for covered services received from or authorized by the member's PCP or medical group, not to exceed the negotiated rate for some services.

Plan payments are based on covered expense, which is the lesser of either the charges billed by either the PPO, non-PPO or Other Health Care provider or:

Blue Cross PPO Providers—The Blue Cross PPO negotiated rate or fee. Members are not responsible for the difference between the providers usual charges & the negotiated amount.

Non-PPO & Other Health Care Providers (*includes those not represented in the Blue Cross PPO provider network*)—The customary & reasonable charge for professional services or the reasonable charge for institutional services.

When using Non-PPO & Other Health Care Providers, members are responsible for any difference between the covered expense & actual charges, as well as any deductible & percentage copays.

	HMO	Providers PPO	Non-PPO
Calendar year deductible for PPO/non-PPO providers	N/A	\$250/member; \$750/family	
Deductible for non-Blue Cross PPO hospital or residential treatment center (<i>waived for emergency admission</i>)	N/A	N/A	\$500/admission
Deductible for non-Blue Cross PPO hospital, residential treatment center or ambulatory surgical center if services not preauthorized (<i>waived for emergency admission</i>)	N/A	N/A	\$250/admission
Annual out-of-pocket maximums (<i>HMO & PPO/non-PPO out-of-pocket maximums are exclusive of each other</i>)	\$1,500/member \$3,000/family		\$3,000/member
For HMO services: percentage copay for infertility services & non-covered expense are not applied to the out-of-pocket maximum.		out-of-pocket maximum. After a member reaches out-of-pocket maximum, the member remains responsible for dollar copays, percentage copays for family planning services (counseling & visit), sterilization for males & females, physician visits for outpatient mental disorders & chemical dependency, and, for non-PPO & other health care providers' services, costs in excess of the covered expense.	
For PPO & Non-PPO services: deductibles listed above, dollar copays, percentage copays for family planning (counseling & visit), sterilization for males & females & physician visits for outpatient mental disorders & chemical dependency & non-covered expense are not applied to the			
Lifetime Maximum	N/A	Combined maximum of \$5,000,000/member	
Covered Services	HMO: Per Member Copay	PPO: Per Member Copay	Non-PPO: Per Member Copay
Hospital Medical Services (<i>preauthorization required for inpatient services at PPO & non-PPO facilities, waived for emergency admission</i>)			
➤ Semi-private room, meals, special diets & ancillary services	No copay	10%	30% ¹
➤ Outpatient medical care (<i>hospital care other than emergency room services</i>)	No copay	10%	30% ¹
Ambulatory Surgical Center (<i>preauthorization required for PPO & non-PPO facilities, waived for emergency admission</i>)			
➤ Outpatient surgery, services & supplies	No copay	10%	30% (<i>limited to \$350/day</i>)
Skilled Nursing Facility (<i>PPO & non-PPO providers' services will not be covered if services are not preauthorized</i>)			
➤ Semi-private room & necessary services & supplies (<i>excludes take-home drugs; medical conditions & severe mental disorders limited to 100 days/calendar year; treatment of other mental disorders & chemical dependency limited to 30 days/calendar year</i>)	No copay	10%	30%

¹For California facilities, a discount applies if the facility has a contract with Blue Cross for fee-for-service business. For California facilities without a contract, covered expense for non-emergency hospital services and supplies is reduced by 25%, resulting in higher out-of-pocket costs for members.

Covered Services	HMO: Per Member Copay	PPO: Per Member Copay	Non-PPO: Per Member Copay
Hospice Care			
➤ Inpatient or outpatient services for members with one year or less life expectancy; family bereavement services	No copay	20% ¹	20% ¹
Home Health Care (PPO & non-PPO providers' services will not be covered if services are not preauthorized; limited to 100 visits/calendar year; one visit by home health aide equals four hours or less)			
	No copay	10%	30%
Physician Medical Services			
➤ Office & home visits	\$10/visit	\$15/visit ² (deductible waived)	30%
➤ Hospital & skilled nursing facility visits	No copay	10%	30%
➤ Surgeon & surgical assistant; anesthesiologist or anesthesiologist	No copay	10%	30%
➤ Specialists & consultants	\$10/visit	\$15/visit ² (deductible waived)	30%
➤ Short-term physical therapy, physical medicine, occupational therapy & chiropractic care (limited to a combined HMO, PPO & non-PPO 60-day period of care after an illness or injury; an additional period of care may be authorized)	\$10/visit	10%	30%
➤ Speech therapy following surgery or when due to an injury or organic disease	No copay	10%	30%
➤ Acupuncture services for the treatment of disease, illness or injury (limited to \$25/visit & 12 visits/calendar year)	Not covered	10% ³	30% ³
General Medical Services			
➤ Diagnostic X-ray & laboratory procedures (excluding X-ray & lab services performed for a routine exam)	No copay	10%	30%
➤ Radiation therapy, chemotherapy & hemodialysis treatment	No copay	10%	30%
➤ Prosthetic devices (PPO & non-PPO providers limited to \$1,000/calendar year except for prostheses following a mastectomy or prosthetic devices following a laryngectomy)	No copay	10%	30%
➤ Durable Medical Equipment including hearing aids (limited to \$2,000/calendar year)	No copay	10%	30%
Organ & Tissue Transplants (preauthorization required)			
➤ Inpatient services provided in connection with non-investigative organ or tissue transplants	No copay	10% (specified organ transplants covered only at Center of Expertise)	
➤ Physician office visits (including specialists & consultants)	\$10/visit	\$15/visit ² (deductible waived)	
➤ Transplant travel expense for an authorized, specified transplant at a Center of Expertise (recipient & companion transportation limited to 6 trips/episode & \$250/person/trip for round-trip coach airfare, hotel limited to 1 room double occupancy/\$100/day for 21 days/trip, other expenses limited to \$25/day/person for 21 days/trip; donor transportation limited to 1 trip/episode & \$250 for round-trip coach airfare, hotel limited to \$100/day for 7 days, other expenses limited to \$25/day for 7 days)	Not covered	No copay (deductible waived)	
Autologous blood (self-donated blood collection, testing, processing & storage)			
	No copay	20% ¹	20% ¹
Injections & injected substances (including allergy serum & medication)			
	No copay	10%	30%
Preventive Care			
➤ Routine physical exams performed by a physician	\$10/visit	Not covered	Not covered
➤ Routine gynecological exams for females, including Pap smears & mammograms	\$10/visit	10%	30%
		(limited to 1 exam/calendar year)	
➤ Prostate cancer screenings	\$10/visit	10%	30%
➤ Diagnostic X-ray & lab for routine physical exam	No copay	Not covered	Not covered
➤ Well-baby & well-child care	\$10/visit	Not covered	Not covered

¹ These providers are not represented in the Blue Cross PPO network

² The dollar copay applies only to the visit itself. An additional 10% copay applies for any services performed in office (i.e., X-ray, lab, surgery, etc.).

³ Acupuncture services can be performed by a certified acupuncturist (C.A.), a doctor of medicine (M.D.), a doctor of osteopathy (D.O.), a podiatrist (D.P.M.), or a dentist (D.D.S.).

Covered Services	HMO: Per Member Copay	PPO: Per Member Copay	Non-PPO: Per Member Copay
Preventive Care (continued)			
➤ Hearing exams	\$10/visit	Not covered	Not covered
➤ Specified immunizations	No copay	Not covered	Not covered
➤ Allergy testing & treatment (<i>including serums</i>)	No copay	10%	30%
Vision Exams			
➤ Vision screening to determine medical necessity of vision exam; evaluation with initiation of diagnostic & treatment programs & refractions if authorized by the PCP	\$10/visit	Not covered	Not covered
Health Education & Wellness Programs			
➤ Instruction in health maintenance & wellness	No copay	Not covered	Not covered
➤ Health education programs (<i>as announced</i>)	Possible charge	Not covered	Not covered
Emergency Care			
➤ Physician & medical services	No copay	No copay	No copay
➤ Outpatient hospital emergency room services	\$100/visit (<i>waived if admitted</i>)	\$100/visit (<i>waived if admitted</i>)	\$100/visit (<i>waived if admitted</i>)
➤ Inpatient hospital services (<i>for PPO providers, 10% after the first 48 hours unless the member cannot be moved safely; for non-PPO providers, 30%¹ after the first 48 hours unless the member cannot be moved safely</i>)	No copay	No copay	No copay
Ambulance			
➤ Ground or air ambulance transportation when medically necessary, including medical services & supplies	No copay	20% ¹	20% ¹
Pregnancy & Maternity Care			
➤ Physician office visits	\$10/visit	\$15/visit ² (<i>deductible waived</i>)	30%
Normal delivery, cesarean section, complications of pregnancy & therapeutic abortion			
➤ Inpatient physician services	No copay	10%	30%
➤ Alternative birthing centers	No copay	10%	30%
➤ Hospital & ancillary services	No copay	10%	30% ³
Elective Abortions (<i>including prescription drug for abortion [mifepristone]</i>)	\$150	10%	30%
Genetic testing of fetus	No copay	10%	30%
Family planning services			
➤ Infertility studies & tests	50% ⁴	Not covered	Not covered
➤ Tubal ligation	\$150	50% ⁴	50% ⁴
➤ Vasectomy	\$75	50% ⁴	50% ⁴
➤ Counseling & consultation	No copay	50% ⁴	50% ⁴
Mental Disorders & Chemical Dependency			
➤ Facility-based care including physician visits (<i>preauthorization required for PPO & non-PPO facilities; waived for emergency admissions; limited to 30 days/calendar year; the 30 days/calendar year limit does not apply to inpatient detoxification</i>)	No copay ⁵	No copay ⁵	30% ^{3,5}
➤ Physician outpatient visits for psychotherapy & psychological testing (<i>limited to 1 visit/day & 20 visits/calendar year</i>)	\$20/visit ⁵	\$20/visit ^{4,5}	50% ^{4,5}

¹ These providers are not represented in the Blue Cross PPO network.

² The dollar copay applies only to the visit itself. An additional 10% copay applies for any services performed in office (i.e., X-ray, lab, surgery, etc.).

³ For California facilities, a discount applies if the facility has a contract with Blue Cross for fee-for-service business. For California facilities without a contract, covered expense for non-emergency hospital services and supplies is reduced by 25%, resulting in higher out-of-pocket costs for members.

⁴ The member's copay is not applicable to the annual out-of-pocket maximum.

⁵ These limitations, copays and benefit maximums do not apply to severe mental disorders, including schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia, bulimia, and serious emotional disturbances of children as defined in California state law (other than primary substance abuse or developmental disorder). Severe mental disorders are subject to the same copays and benefit maximums applicable to other medical conditions for covered services. In order to receive maximum benefits, services must be rendered by a Blue Cross behavioral health provider. Please see the EOC for complete information.

This is a brief summary of benefits. For complete information, including the terms and conditions of this plan and the complete exclusions and limitations, please refer to the Evidence of Coverage and Disclosure Form.

51-125 Blue Cross POS—Exclusions and Limitations

Medical care not covered under HMO benefits:

Not Authorized. Any services not authorized by the member's primary care physician or medical group, except for emergency services and urgent care and as otherwise specified as covered in the Evidence of Coverage (EOC).

Services Provided by Non-Participating Providers. Any services provided by a non-participating provider, except for authorized referrals, emergency services or urgent care as specified as covered in the EOC.

Hearing Aids. Hearing aids or services related to the fitting or making of a hearing aid, except as specified as covered in the EOC.

Optometric Services or Supplies. Optometric services, vision eye exercises and orthoptics, except for eye examinations to determine the need for vision correction. Eyeglasses or contact lenses, except as specified as covered in the EOC. Contact lens fitting.

Surrogacy. Any services or supplies provided in connection with a surrogate pregnancy, i.e., the bearing of a child by another woman for an infertile couple, unless the surrogate mother is an enrolled Blue Cross POS (Plus) member.

Sexual Dysfunction. Treatment of any sexual dysfunction, except as specified as covered in the EOC.

Routine Examinations. Routine physical or psychological examinations or tests required by employment or government authority, or at the request of a third party such as a school, camp or sport affiliated organization. Any other routine physical or psychological examination or test which does not directly treat an actual illness, injury or condition, except as specified as covered in the EOC.

Immunizations. Immunizations for foreign travel. Immunizations, except as specified as covered in the EOC.

Acupuncture. Acupuncture, acupressure or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatomes or acupuncture points.

Outpatient Drugs or Medicine and Insulin. This exclusion includes but is not limited to:

1. Any drug or medicine requiring or dispensed with a written prescription of a physician;
2. Any non-prescription, over-the-counter patent or proprietary drug or medicine; and
3. Cosmetics, health or beauty aids.
4. This exclusion does not apply to drugs administered by an authorized home health.

Medical care not covered under Opt-out Benefits

Outside the United States. Services or supplies furnished and billed by a provider outside the United States, unless such services or supplies are furnished in connection with urgent care or emergency care.

Excess Amounts. Any amounts in excess of covered expense or the opt-out medical benefit maximums.

HMO Benefits. Services or supplies for which any benefits are authorized, provided and received under the HMO benefits of the plan, including any authorized services received for the treatment of an emergency. Services and supplies provided by the member's primary care physician or services provided through the ReadyAccess Program.

Excluded under HMO. Services or supplies which are excluded under the HMO benefits of the plan, except to the extent that the services of a provider who is not a participating provider in the Blue Cross POS (Plus) network are payable under the opt-out benefit of the plan.

Services of Relatives. Professional services received from a person who lives in the member's home or who is related to the member by blood or marriage, except as specified as covered in the EOC.

Inpatient Diagnostic Tests. Inpatient room and board charges in connection with a hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.

Hearing Aids or Tests. Hearing aids, except as specified as covered in the EOC. Routine hearing tests.

Optometric Services or Supplies. Optometric services, eye exercises including orthoptics, routine eye exams and routine eye refractions. Eyeglasses or contact lenses, except as specified as covered in the EOC.

Outpatient Occupational Therapy. Outpatient occupational therapy, except by a home health agency, hospice or home infusion therapy provider as specified as covered in the EOC.

Education or Counseling. Educational services, or nutritional counseling, except as specified as covered in the EOC.

Routine Exams or Tests. Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment or government authority. Any other routine physical examination or test which does not directly treat an actual illness, injury or condition, except as specified as covered in the EOC.

Outpatient Prescription Drugs and Medications. Outpatient prescription drugs or medications and insulin, except as specified as covered in the EOC. Any non-prescription, over-the-counter patent or proprietary drug or medicine. Cosmetics, health or beauty aids.

Medical care not covered under HMO and Opt-out Benefits

Not Medically Necessary. Services or supplies that are not medically necessary, as defined.

Experimental or Investigative. Any experimental or investigative procedure or medication. But, if member is denied benefits because it is determined that the requested treatment is experimental or investigative, the member may request an independent medical review, as described in the EOC.

Crime or Nuclear Energy. Conditions that result from: (1) the member's commission of or attempt to commit a felony; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available for treatment of illness or injury arising from such release of nuclear energy.

Not Covered. Services received before the member's effective date. Services received after the member's coverage ends, except as specified as covered in the EOC.

Work-Related. Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, even if the member does not claim those benefits. If there is a dispute of substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers' compensation, we will provide the benefits of this plan for such conditions, subject to a right of recovery and reimbursement under California Labor Code Section 4903, as specified as covered in the EOC.

Government Treatment. Any services the member actually received that were provided by a local, state or federal government agency, except when payment under this plan is expressly required by federal or state law. We will not cover payment for these services if the member is not required to pay for them or they are given to the insured person for free.

Voluntary Payment. Services for which the member is not legally obligated to pay. Services for which the member is not charged. Services for which no charge is made in the absence of insurance coverage, except services received at a non-governmental charitable research hospital. Such a hospital must meet the following guidelines:

1. It must be internationally known as being devoted mainly to medical research;
2. At least 10% of its yearly budget must be spent on research not directly related to patient care;
3. At least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;
4. It must accept patients who are unable to pay; and
5. Two-thirds of its patients must have conditions directly related to the hospital's research.

Not Specifically Listed. Services not specifically listed in the plan as covered services.

Private Contracts. Services or supplies provided pursuant to a private contract between the member and a provider, for which reimbursement under Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

Nutrition. Food or nutritional supplements, except as specified as covered in the EOC.

Mental Disorders. Academic or educational testing, counseling, and remediation. Mental disorders or chemical dependency, including rehabilitative care in relation to these conditions, except as specified as covered in the EOC.

Nicotine Use. Smoking cessation programs or treatment of nicotine or tobacco use. Smoking cessation drugs.

Orthodontia. Braces, other orthodontic appliances or orthodontic services.

Dental Services or Supplies. Dental plates, bridges, crowns, caps or other dental prostheses, dental services, extraction of teeth or treatment to the teeth or gums, except as specified as covered in the EOC. Cosmetic dental surgery or other dental services for beautification.

Outpatient Speech Therapy. Outpatient speech therapy, except as specified as covered in the EOC.

Cosmetic Surgery. Cosmetic surgery or other services performed solely for beautification or to alter or reshape normal (including aged) structures or tissues of the body to improve appearance. This exclusion does not apply to reconstructive surgery (that is, surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or to create a normal appearance), including surgery performed to restore symmetry following mastectomy. Cosmetic surgery does not become reconstructive surgery because of psychological or psychiatric reasons.

Weight Alteration Programs (Inpatient and Outpatient). Weight loss or weight gain programs including, but not limited to, dietary evaluations and counseling, exercise programs, behavioral modification programs, surgery, laboratory tests, food and food supplements, vitamins and other nutritional supplements associated with weight loss or weight gain, unless it is for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity will be covered only when criteria are met as recommended by our Medical Policy.

Sex Transformation. Procedures or treatments to change characteristics of the body to those of the opposite sex.

Sterilization Reversal.

Infertility Treatment. Artificial insemination or in vitro fertilization procedures and any related laboratory procedures. Infertility treatment, family planning or birth control services, except as specified as covered in the EOC.

Orthopedic Supplies. Orthopedic supplies, orthopedic shoes (other than shoes joined to braces), or non-custom molded and cast shoe inserts, except for therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications as specified as covered in the EOC.

Air Conditioners. Air purifiers, air conditioners or humidifiers.

Custodial Care or Rest Cures. Inpatient room and board charges in connection with a hospital stay primarily for environmental change or physical therapy. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a skilled nursing facility or custodial care or rest cures, except as specified as covered in the EOC.

Chronic Pain. Treatment of chronic pain, except as specified as covered in the EOC.

Exercise Equipment. Exercise equipment or any charges for activities, instrumentalities or facilities normally intended or used for developing or maintaining physical fitness including, but not limited to, charges from a physical fitness instructor, health club or gym, even if ordered by a physician.

Personal Items. Any supplies for comfort, hygiene or beautification.

Telephone and Facsimile Machine Consultations. Consultations provided by telephone or facsimile machine.

Eye Surgery for Refractive Defects. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery.

Physical Therapy or Physical Medicine. Services of a physician for physical therapy or physical medicine, except when provided during a covered inpatient confinement or as specified as covered in the EOC.

Contraceptive Devices. Contraceptive devices prescribed for birth control except as specified as covered in the EOC.

Diabetic Supplies. Prescription and non-prescription diabetic supplies except as specified as covered in the EOC.

Private Duty Nursing. Inpatient or outpatient services of a private duty nurse.

Lifestyle Programs. Programs to alter one's lifestyle which may include but are not limited to diet, exercise, imagery or nutrition. This exclusion will not apply to cardiac rehabilitation programs approved by the member's medical group or, under the opt-out benefits, approved by us.

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Third Party Liability – Blue Cross of California is entitled to reimbursement of benefits paid if the member recovers damages from a legally liable third party.

Coordination of Benefits – The benefits of this plan may be reduced if the member has any other group health or dental coverage so that the services received from all group coverages do not exceed 100% of the covered expense.

The Power of Blue.SM

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