

Los Angeles Community College District  
 Blue Shield of California PPO Plan  
 Member Services: 1-800-443-5005

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

Benefit Summary

<b>DEDUCTIBLES<sup>#</sup></b>	<b>Preferred Providers<sup>1</sup></b>	<b>Non-Preferred Providers<sup>1</sup></b>
<b>Calendar-year Medical Deductible</b>		
• Per individual/per family	\$200/\$600 combined in and out of network	\$200/\$600 combined in and out of network
<b>Calendar-year Copayment Maximum<sup>#</sup></b>		
• Per individual/per family	None	\$1,000/\$3,000
<b>LIFETIME MAXIMUMS</b>	\$6,000,000	
<b>Covered Services</b>	<b>Member Coinsurance</b>	
<b>PROFESSIONAL SERVICES</b>		
<b>Physician services</b>		
• Physician and specialist office visits	\$10 copay*	20%
• Laboratory and X-rays	No Charge	20%
• Allergy testing or treatment	No Charge	20%
• Diagnostic testing, including MRI, CAT, PET, Bone scans, etc.	No Charge	20%
<b>Preventive care</b>		
• Annual physical exam, eye/ear screenings and immunizations according to age schedule, inc. colonoscopy according to age schedule	No Charge*	20%
• Laboratory, including mammogram and Pap test screening or other FDA-approved cervical cancer screening tests (One per calendar year)	No Charge*	20%
<b>Well-baby care</b>		
• Office visits and consultations Includes: eye/ear screenings, immunizations, vaccinations	No Charge*	20%
• Laboratory	No Charge	20%
<b>OUTPATIENT SERVICES</b>		
• Outpatient surgery in hospital/facility	No Charge	20%
• Outpatient treatment, renal dialysis and necessary supplies	No Charge	20%
<b>HOSPITALIZATION SERVICES</b>		
• Inpatient physician services (including pregnancy and maternity care)	No Charge	20%
• Semi-private room and board, medically necessary services and supplies	No Charge	20%
<b>Skilled nursing facility (SNF) services<sup>2</sup></b> (Combined maximum of up to 100 preauthorized days per calendar year; semi-private accommodations)		
• Freestanding SNF	No Charge	No Charge with prior authorization <sup>2</sup>
• Hospital SNF unit	No Charge	20%
<b>EMERGENCY HEALTH COVERAGE</b>		
• Facility services (Not resulting in a direct admission)	No Charge* <sup>#</sup>	
• Facility services (Resulting in a direct admission)	No Charge	No Charge
• Emergency room physician services	No Charge	No Charge
<b>AMBULANCE SERVICES</b>		
	No Charge	No Charge
<b>PRESCRIPTION DRUG COVERAGE</b> Includes oral contraceptives, diaphragms, and covered diabetic drugs and testing supplies; Home self-injectables (HSI) are covered through both retail and the contracted specialty network for injectables.		
	<b>Participating Pharmacies</b> Retail and Mail-Order: \$5/Generic \$15/Formulary Brand \$35/Non-Formulary Brand \$30/HSI	<b>Non-participating Pharmacies</b> Retail : \$5/Generic \$15/Formulary Brand \$35/Non-Formulary Brand \$30/HSI
<b>DURABLE MEDICAL EQUIPMENT</b>		
• Home medical equipment, prosthetics/orthotics – maximum payment on orthosis \$2,000 CAY	No Charge	20%
• Hearing Aid benefit: \$2,000 maximum payment every 24 months	20%	20%

Covered Services	Member Coinsurance	
	MHSA Participating Providers <sup>1</sup>	MHSA Non-Participating Providers <sup>1</sup>
<b>MENTAL HEALTH SERVICES (PSYCHIATRIC)<sup>3</sup></b>		
• Inpatient hospital facility services	No Charge	20%
• Outpatient visits for severe mental health conditions	\$10*	20%
• Outpatient visits for non-severe mental health conditions (Up to 20 visits per calendar year combined with outpatient chemical dependency visits; in and out-of-network receive 20 visits) <sup>4</sup>	\$25 <sup>#</sup>	20%
<b>CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)<sup>3</sup>,</b>		
• Inpatient services for medical acute detoxification	No charge for medical detox. 10% for 30 day inpatient benefit	20% for medical detox.. 10% for 30 day inpatient benefit
• Outpatient visits (Up to 20 visits per calendar year combined with outpatient non-severe mental health visits; in and out-of-network receive 20 visits each) <sup>4</sup>	\$25	20%
<b>HOME HEALTH SERVICES<sup>2</sup></b> (Combined maximum of 100 prior authorized visits per calendar year)	<b>Preferred Providers<sup>1</sup></b>	<b>Non-Preferred Providers<sup>1</sup></b>
• Home health and home infusion care (See "Prescription Drug Coverage" for home self-administered injectables.)	No Charge	No charge
<b>Hospice<sup>2</sup></b>		
• Routine home care and inpatient respite care	No Charge	No Charge
• 24 hour continuous home care and general inpatient care	No Charge	No Charge with prior authorization
<b>Alternative care<sup>4</sup></b>		
• Chiropractic services (Up to 24 visits per calendar year)	No Charge	20%
• Acupuncture services (Up to 24 visits per calendar year)	No Charge	20%
<b>Rehabilitative therapy services</b>		
• Outpatient visits, including speech, occupational, respiratory, physical therapies	No Charge	20%
<b>Pregnancy and maternity care</b>		
• Prenatal and postnatal physician office visits (For all necessary inpatient hospital services, see "Hospitalization Services.")	No Charge	20%
<b>Family planning</b>		
• Family planning counseling	\$10 *	20%
• Elective abortion, tubal ligation, vasectomy	No Charge	20%
<b>Covered out-of-state benefits</b> Benefits provided through BlueCard <sup>®</sup> 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.	Same as in-state	Same as in-state
<b>Diabetes care</b>		
• Equipment, devices and non-testing supplies (For testing supplies, see "Prescription Drug Coverage.")	No Charge	20%
• Self-management training and education	\$10*	20%

\* Benefits are not subject to the calendar-year medical deductible.

# Copayments and charges for services not accruing to the member's calendar-year copayment maximum continue to be the member's responsibility after the calendar-year copayment maximum is reached. Deductible does not apply toward the calendar-year maximum. Please refer to the *Evidence of Coverage*, the *Disclosure Form* and the *Group Health Service Contract* for exact terms and conditions of coverage.

1 Member is responsible for copayment in addition to any charges above allowable amounts. The copayment percentage indicated is a percentage of allowable 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 above the allowable amount do not count toward the calendar-year deductible or copayment maximum.

2 Services may require prior authorization by Blue Shield. When these services are prior authorized, members pay the preferred or participating provider amount.

3 Mental health and chemical dependency services, other than medical acute detoxification, are accessed through the mental health services administrator (MHSA) using MHSA participating and non-participating providers. Services for medical acute detoxification are accessed through Blue Shield using Blue Shield's preferred providers or non-preferred providers. 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.

4 All outpatient non-severe mental health, outpatient substance abuse, acupuncture and chiropractic visits accrue to the calendar-year visit maximum regardless of whether the plan deductible has been met.

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

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