Shield Spectrum PPO℠ Plan 500 Premier

Benefit Summary (For groups 2 to 50)
(Uniform Health Plan Benefits and Coverage Matrix)

Blue Shield of California

Effective January 1, 2011

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

DEDUCTIBLES[1] (All providers combined)	**Preferred Providers**[2]	**Non-Preferred Providers**[2]
Calendar-year Medical Deductibles	$500 per individual/$1,000 per family	
Calendar-year Copayment Maximum[1] (Copayments for Preferred Providers accrue to both Preferred and Non-Preferred Provider Calendar-year Copayment Maximum amounts)	$3,500 per individual/$7,000 per family	$10,000 per individual/$20,000 per family
LIFETIME MAXIMUM	None	
Covered Services	**Member Copayment**	
PROFESSIONAL SERVICES		
Physician services		
• Physician and specialist office visits	$35/visit (Not subject to the Calendar-year Medical Deductible)	40%[1]
• Laboratory and X-rays	20%	40%
• Allergy testing or treatment	20%	40%
• Diagnostic testing	20%	40%
Preventive care		
• Annual routine physical exam, eye/ear screenings and immunizations	No charge (Not subject to the Calendar-year Medical Deductible)	Not covered
• Laboratory, including mammogram and Pap test screening or other FDA-approved cervical cancer screening tests (One per calendar-year)	No charge (Not subject to the Calendar-year Medical Deductible)	Not covered
Well-baby care		
• Office visits and consultations Includes: eye/ear screenings, immunizations, vaccinations	No charge (Not subject to the Calendar-year Medical Deductible)	Not covered
• Laboratory	No charge (Not subject to the Calendar-year Medical Deductible)	Not covered
OUTPATIENT SERVICES		
• Outpatient surgery performed in a participating ambulatory surgery center (ASC)[3]	20%	40%[4]
• Outpatient surgery in hospital/facility	$150/surgery[1] + 20%	40%[4]
• Outpatient treatment and necessary supplies	20%	40%[1, 4]

• Bariatric surgery **(pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity)**[5]	$150/surgery[1] + 20%	40%[4]

Covered Services	**Member Copayment**	
HOSPITALIZATION SERVICES		
• Inpatient physician services (including pregnancy and maternity care)	20%	40%
• Semi-private room and board, medically necessary services and supplies	$250/admission + 20%	40%[4]
• Bariatric surgery **(pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity)**[5]	$250/admission + 20%	40%[4]
Skilled nursing facility (SNF) services[6] (Combined maximum of up to 100 preauthorized days per calendar-year; semi-private accommodations)		
• Freestanding SNF	20%	20%
• Hospital SNF unit	20%	40%[4]
EMERGENCY HEALTH COVERAGE		
• Facility services (If ER services do not result in a direct admission the Calendar-Year Deductible does not apply)	$100/visit[1] + 20%	$100/visit[1] + 20%
• Facility services (Resulting in a direct admission)	$250/admission + 20%	$250/admission + 20%
• Emergency room physician visits	20%	20%
AMBULANCE SERVICES	20%	20%
PRESCRIPTION DRUG COVERAGE[1, 7, 8 , 14] (Including oral contraceptives, diaphragms, and covered diabetic drugs and testing supplies)	**Participating Pharmacy**	**Non-Participating Pharmacy** Member pays 25% of allowed charge plus a copayment of:
• Calendar-Year Brand-Name Drug Deductible	$150 per member per calendar-year applies to all covered brand-name and specialty drugs.	
• Retail prescriptions (For up to a 30-day supply)		
Generic drugs	$10/prescription	$10/prescription
Formulary brand-name drugs	$30/prescription	$30/prescription
Non-formulary brand-name drugs	$50/prescription	$50/prescription
• Mail service prescriptions (For up to a 90-day supply)		
Generic drugs	$20/prescription	Not covered
Formulary brand-name drugs	$60/prescription	Not covered
Non-formulary brand-name drugs	$100/prescription	Not covered
• Specialty Pharmacies		
Specialty drugs (may require prior authorization from Blue Shield Pharmacy Services. Specialty drugs are covered only when dispensed by select participating pharmacies in the specialty pharmacy network. Mail service prescriptions are not covered. Drugs from non-participating pharmacies are not covered except in emergency and urgent situations. **Member pays up to $100 copayment maximum per prescription)**	30%/prescription	Not covered
PROSTHETICS/ORTHOTICS	**Preferred Providers**[2]	**Non-Preferred Providers**[2]
• Prosthetic appliances and orthoses benefits (Equipment and devices only. Separate office visit copayment may apply)	20%	40%
DURABLE MEDICAL EQUIPMENT	50%	50%
MENTAL HEALTH SERVICES (PSYCHIATRIC)[9]	**MHSA Participating Providers**[2]	**MHSA Non-Participating Providers**[2]
• Inpatient hospital facility services	$250/admission + 20%	40%[4]
• Outpatient visits for severe mental health conditions	$35/visit (Not subject to the Calendar-year Medical Deductible)	40%[1]
• Outpatient visits for non-severe mental health conditions (Up to 20 visits per calendar-year combined with outpatient chemical dependency visits)[10]	50%[1]	Not covered

Covered Services	Member Copayment	
CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)[9], PLEASE SEE FOOTNOTE 13		
• Inpatient services for medical acute detoxification	$250/admission + 20%	40%[4]
• Outpatient visits (Up to 20 visits per calendar-year combined with outpatient non-severe mental health visits)[10]	50%[1]	Not covered
HOME HEALTH SERVICES	**Preferred Providers[2]**	**Non-Preferred Providers[2]**
• Home health (Maximum of 100 prior authorized visits per calendar-year)	20%	Not covered[11]
• Home infusion care (For specialty drugs see "Specialty Pharmacies.")	20%	Not covered[11]
OTHER		
Hospice		
• Routine home care	No charge	Not covered[11]
• Inpatient respite care	No charge	Not covered[11]
• 24 hour continuous home care	20%	Not covered[11]
• General inpatient care	20%	Not covered[11]
Alternative care[10]		
• Chiropractic services (Up to 12 visits per calendar-year)	20%	40%
• Acupuncture services	Not covered	Not covered
Rehabilitative therapy services		
• Outpatient visits	20%	40%
Pregnancy and maternity care		
• Prenatal and postnatal professional (physician) services (For all necessary inpatient hospital services, see "Hospitalization Services.")	20%	40%
Family planning		
• Family planning counseling	20% (Not subject to the Calendar-year Medical Deductible)	Not covered
• Elective abortion[12], tubal ligation[12], vasectomy[12]	20%	Not covered
Diabetes care		
• Equipment, devices and non-testing supplies (For testing supplies, see "Prescription Drug Coverage.")	50%	50%
• Self-management training and education (If billed by your provider, you will also be responsible for the office visit copayment)	$35/visit	40%
Covered out-of-state benefits Benefits provided through BlueCard® 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.	See Applicable Benefit Line	See Applicable Benefit Line
Optional Benefits	Optional dental, vision, or infertility benefit is available. If your employer purchased any of these benefits, a description of the benefit is provided separately.	

1 Deductible and copayments marked with a (1) do not accrue to calendar-year copayment maximum, except for the percentage copayment for the Outpatient Surgery in hospital/facility benefit which does accrue to the calendar-year copayment maximum. 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* and the plan contract for exact terms and conditions of coverage.

2 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.

3 Participating ambulatory surgery centers may not be available in all areas. Regardless of their availability, you can obtain outpatient surgery services from a hospital or an ambulatory surgery center affiliated with a hospital, with payment according to your health plan's hospital services benefits.

4 The maximum allowed charges for non-emergency hospital services received from a Non-Preferred Hospital are $600 per day. Members are responsible for 40% of this $600 per day, plus all charges in excess of $600.

5 Bariatric surgery is covered when pre-authorized by Blue Shield. However, for members residing in Imperial, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Barbara and Ventura Counties ("Designated Counties"), bariatric surgery services are covered only when performed at designated contracting bariatric surgery facilities and by designated contracting surgeons; coverage is not available for bariatric services from any other preferred provider and there is no coverage of bariatric services from non-preferred providers. In addition, if prior authorized by Blue Shield of California, a member in a Designated County who is required to travel more than 50 miles to a designated bariatric surgery facility will be eligible for limited reimbursement for specified travel expenses for the member and one companion. Refer to the *Evidence of Coverage* for further benefit details.

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

7 Please note that if you switch from another plan, your prescription drug deductible credit from the previous plan during the calendar year, if applicable, will not carry forward to your new plan. This plan's prescription drug coverage is on average equivalent to or better than the standard benefit set by the federal government for Medicare Part D (also called "creditable" coverage). Since this plan's prescription drug coverage is creditable, you do not have to enroll in Medicare Part D while you maintain this coverage; however, you should be aware that if you have a subsequent break in this coverage of 63 days or more before enrolling in Medicare Part D you could be subject to payment of higher Medicare Part D premiums.

8 If the member requests a brand-name drug when a generic drug equivalent is available, the member is responsible for paying the difference between the cost to Blue Shield of California for the brand-name drug and its generic drug equivalent, as well as the applicable generic drug copayment.

9 Mental health and chemical dependency services, other than medical acute detoxification, are accessed through Blue Shield's Mental Health Service Administrator (MHSA) – using Blue Shield MHSA participating and non-participating providers. Only Blue Shield MHSA contracted providers are administered by the Blue Shield MHSA. Behavioral health services rendered by non-participating providers are administered by Blue Shield. 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.

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

11 Out of network home health care, home infusion and hospice services are not covered unless pre-authorized. When these services are pre-authorized, the member pays the Preferred benefits.

12 Copayment shown is for physician's services. If the procedure is performed in a facility setting (hospital or outpatient surgery center), an additional facility copayment may apply.

13 **Optional inpatient substance abuse treatment benefits are available. If your employer purchased these benefits, a description of the benefit is attached hereto as "*Additional Substance Abuse Treatment Benefits*".**

14 Specialty Drugs are specific Drugs used to treat complex or chronic conditions which usually require close monitoring such as multiple sclerosis, hepatitis, rheumatoid arthritis, cancers, and other conditions that are difficult to treat with traditional therapies. Specialty Drugs are listed in the Blue Shield Outpatient Drug Formulary. Specialty Drugs may be self-administered in the home by injection by the patient or family member (subcutaneously or intramuscularly), by inhalation, orally or topically. Infused or Intravenous (IV) medications are not included as Specialty Drugs. These Drugs may also require special handling, special manufacturing processes, and may have limited prescribing or limited pharmacy availability. Specialty Drugs must be considered safe for self-administration by Blue Shield's Pharmacy & Therapeutics Committee, be obtained from a Blue Shield Specialty Pharmacy and may require prior authorization for Medical Necessity by Blue Shield.

Plan designs may be modified to ensure compliance with state and federal requirements.