# Shield Spectrum PPO℠ Plan 500 Standard

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

## Blue Shield of California
## Life & Health Insurance Company

Effective January 1, 2011

**THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE *CERTIFICATE OF INSURANCE* AND GROUP POLICY 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) | $4,000 per individual/$8,000 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 | $40/visit (Not subject to the Calendar-year Medical Deductible) | 50%[1] |
| • Laboratory and X-rays | 30% | 50% |
| • Allergy testing or treatment | 30% | 50% |
| • Diagnostic testing | 30% | 50% |
| **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] | 30% | 50%[4] |
| • Outpatient surgery in hospital/facility | $250/surgery[1] + 30% | 50%[4] |
| • Outpatient treatment and necessary supplies | 30% | 50%[1, 4] |
| • Bariatric surgery (Pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity)[5] | $250/surgery[1] + 30% | 50%[4] |

| Covered Services | Member Copayment | |
|---|---|---|
| **HOSPITALIZATION SERVICES** | | |
| • Inpatient physician services (including pregnancy and maternity care) | 30% | 50% |
| • Semi-private room and board, medically necessary services and supplies | $500/admission + 30% | 50%[4] |
| • Bariatric surgery (Pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity)[5] | $500/admission + 30% | 50%[4] |
| **Skilled nursing facility (SNF) services**[6] (Combined maximum of up to 60 preauthorized days per calendar-year; semi-private accommodations) | | |
| • Freestanding SNF | 30% | 30% |
| • Hospital SNF unit | 30% | 50%[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] + 30% | $100/visit[1] + 30% |
| • Facility services (Resulting in a direct admission) | $500/admission + 30% | $500/admission + 30% |
| • Emergency room physician visits | 30% | 30% |
| **AMBULANCE SERVICES** | 30% | 30% |
| **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 | $250 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 Life 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) | 30% | 50% |
| **DURABLE MEDICAL EQUIPMENT** | 50% | 50% |

| Covered Services | Member Copayment | |
|---|---|---|
| **MENTAL HEALTH SERVICES (PSYCHIATRIC)**[9] | **MHSA Participating Providers**[2] | **MHSA Non-Participating Providers**[2] |
| • Inpatient hospital facility services | $500/admission + 30% | 50%[4] |
| • Outpatient visits for severe mental health conditions | $40/visit (Not subject to the Calendar-year Medical Deductible) | 50%[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 |
| **CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)**[9]**, PLEASE SEE FOOTNOTE 13** | | |
| • Inpatient services for medical acute detoxification | $500/admission + 30% | 50%[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) | 30% | Not covered[11] |
| • Home infusion care (For specialty drugs see "Specialty Pharmacies.") | 30% | 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 | 30% | Not covered[11] |
| • General inpatient care | 30% | Not covered[11] |
| **Alternative care**[10] | | |
| • Chiropractic services (Up to 12 visits per calendar –year) | 30% | 50% |
| • Acupuncture services | Not covered | Not covered |
| **Rehabilitative therapy services** | | |
| • Outpatient visits | 30% | 50% |
| **Pregnancy and maternity care** | | |
| • Prenatal and postnatal professional (physician) services (For all necessary inpatient hospital services, see "Hospitalization Services.") | 30% | 50% |
| **Family planning** | | |
| • Family planning counseling | 30% (Not subject to the Calendar-year Medical Deductible) | Not covered |
| • Elective abortion[12], tubal ligation[12], vasectomy[12] | 30% | 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) | $40/visit | 50% |
| **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 *Certificate of Insurance* and the group policy for exact terms and conditions of coverage.

2 Member is responsible for copayment in addition to any charges above allowable amounts. The coinsurance indicated is a percentage of allowable amounts. Preferred providers accept Blue Shield of California Life and Health Insurance Company's (Blue Shield Life) 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 Life'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 50% 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 Life, 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 *Certificate of Insurance* for further benefit details.

6 Services may require prior authorization by Blue Shield Life. 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 Life 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 Life's Mental Health Service Administrator (MHSA) – using Blue Shield Life MHSA participating and non-participating providers. Only Blue Shield Life MHSA contracted providers are administered by the Blue Shield Life MHSA. Behavioral health services rendered by non-participating providers are administered by Blue Shield Life. Services for medical acute detoxification are accessed through Blue Shield Life using Blue Shield Life'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 *Certificate of Insurance* or the group policy.

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.*

Shield Spectrum Plan PPO$^{SM}$ 500 Standard is pending regulatory review