

# Shield Spectrum PPO Plan, Zero Deductible

## Benefit Summary (For groups of 51 and above)

(Uniform Health Plan Benefits and Coverage Matrix)

**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.**

Highlights: A description of the prescription drug coverage is provided separately.

There are Choice and Affiliate providers. Different copayments or copayment percentages may apply for Choice or Affiliate providers. Refer to the footnotes for further information.

DEDUCTIBLES <sup>#</sup>	Preferred Providers <sup>1</sup>	Non-Preferred Providers <sup>1</sup>
<b>Calendar-year medical deductible</b>		
• Per individual/per family	\$0/\$0	\$500/\$1,000
<b>Calendar-year copayment maximum<sup>#</sup></b>		
• Per individual/per family	\$2,000/\$4,000	\$5,000/\$10,000
<b>LIFETIME MAXIMUMS</b>	\$6,000,000	

Covered Services	Member Copayment	
<b>PROFESSIONAL SERVICES</b>		
<b>Physician services</b>		
• Physician and specialist office visits	\$10/visit*	30% <sup>#</sup>
• Laboratory and X-rays	\$10/visit	30%
• Allergy testing or treatment	10%	30%
• Diagnostic testing	10%	30%
<b>Preventive care</b>		
• Annual physical exam, eye/ear screenings and immunizations according to age schedule	\$10/visit*	Not covered
• Laboratory, including mammogram and Pap test screening or other FDA-approved cervical cancer screening tests	\$10/visit*	Not covered
<b>Well-baby care</b>		
• Office visits and consultations Includes: eye/ear screenings, immunizations, vaccinations	\$10/visit*	Not covered
• Laboratory	\$10/visit	Not covered
<b>OUTPATIENT SERVICES</b>		
• Outpatient surgery in hospital/facility	10% <sup>2</sup>	30% <sup>3</sup>
• Outpatient treatment, renal dialysis and necessary supplies	10% <sup>2</sup>	30% <sup>3#</sup>
<b>HOSPITALIZATION SERVICES</b>		
• Inpatient physician services (including pregnancy and maternity care)	10%	30%
• Semi-private room and board, medically necessary services and supplies	10% <sup>2</sup>	30% <sup>3</sup>
<b>Skilled nursing facility (SNF) services<sup>4</sup></b> (Up to 100 combined days per calendar year; semi-private accommodations)		
• Freestanding SNF	10%	10% with prior authorization
• Hospital SNF unit	10%	30% <sup>3</sup>
<b>EMERGENCY HEALTH COVERAGE</b>		
• Facility services (The \$50 copayment per emergency room visit is waived if the member is directly admitted to the hospital for inpatient services)	\$50* <sup>#</sup> + 10%*	
• Emergency room physician services	10%	10%
<b>AMBULANCE SERVICES</b>		
	10%	10%
<b>PRESCRIPTION DRUG COVERAGE</b>		
	A description of your outpatient prescription drug coverage is provided separately. If you do not have the separate drug sheet that goes with this matrix, please contact your benefits administrator or call Customer Services at 800-200-3242.	
<b>DURABLE MEDICAL EQUIPMENT</b>		
• Home medical equipment, prosthetics/orthotics <sup>5</sup>	Preferred Providers <sup>1</sup> 10%	Non-Preferred Providers <sup>1</sup> 30%

Covered Services	Member Copayment	
	MHSA Participating Providers <sup>1</sup>	MHSA Non-Participating Providers <sup>1</sup>
<b>MENTAL HEALTH SERVICES (PSYCHIATRIC)<sup>6</sup></b>		
• Inpatient hospital facility services	10%	30% <sup>3</sup>
• Outpatient visits for severe mental health conditions	\$10/visit*	30%#
• Outpatient visits for non-severe mental health conditions (Up to 20 visits per calendar year combined with outpatient chemical dependency visits) <sup>7</sup>	\$25/visit <sup>#</sup>	Not covered
<b>CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)<sup>6</sup> Please see footnote 8</b>		
• Inpatient services for medical acute detoxification	See "Hospitalization Services" \$25/visit <sup>#</sup>	See "Hospitalization Services" Not covered
• Outpatient visits (Up to 20 visits per calendar year combined with outpatient non-severe mental health visits) <sup>7</sup>		
<b>HOME HEALTH SERVICES<sup>4</sup></b> (Combined maximum of 100 prior authorized visits per calendar year)	<b>Preferred Providers<sup>1</sup></b> 10%	<b>Non-Preferred Providers<sup>1</sup></b> 10% with prior authorization
• Home health and home infusion care (See "Prescription Drug Coverage" for home self-administered injectables)		
<b>OTHER</b>		
<b>Hospice<sup>4</sup></b>		
• Routine home care and inpatient respite care	No charge	No charge with prior authorization
• 24 hour continuous home care and general inpatient care	10%	10% with prior authorization
<b>Alternative care<sup>7</sup></b>		
• Chiropractic services (Up to 12 visits per calendar year)	\$25/visit	30%
• Acupuncture services (Up to 20 visits per calendar year)	\$25/visit	\$25/visit
<b>Rehabilitative therapy services</b>		
• Outpatient visits	\$25/visit	30%
<b>Pregnancy and maternity care</b>		
• Prenatal and postnatal physician office visits (For all necessary inpatient hospital services, see "Hospitalization Services.")	10%	30%
<b>Family planning</b>		
• Family planning counseling	\$10/visit*	Not covered
• Elective abortion, tubal ligation, vasectomy	10% <sup>2</sup>	Not covered
<b>Covered out-of-state benefits</b> 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.	10% or \$10 copay	30%
<b>Diabetes care</b>		
• Equipment, devices and non-testing supplies (For testing supplies, see "Prescription Drug Coverage")	10%	30%
• Self-management training and education	\$10/visit	30%
<b>Optional Benefits</b>	Optional dental, vision, or infertility benefits are available. If your employer purchased any of these benefits, a description of the benefit is provided separately.	

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

# Copayments and charges for services not included in the calculation of 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 There are Choice and Affiliate PPO providers. An additional 10 percent member copayment will be charged when non-emergency hospital facility services are obtained from an Affiliate provider.

3 The maximum allowed charges for non-emergency hospital services received from a non-preferred hospital is \$600 per day. Members are responsible for 30 percent of this \$600 per day, plus all charges in excess of \$600.

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

5 Orthosis benefits, except for services covered under diabetes care, are limited to a \$2,000 maximum per person per calendar year.

6 Mental health and chemical dependency services, other than medical acute detoxification, are accessed through the mental health services administrator (MHSA) - US Behavioral Health Plan, California (USBHPC) - 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.

7 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.

8 **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".**

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

