

# Shield Spectrum PPO<sup>SM</sup> Plan 1500 Value<sup>†</sup>

## Benefit Summary

Highlights: (\$500 brand-name drug maximum),  
 \$15/\$30 copay or 30% of Blue Shield Life contracted rate  
 (whichever is greater) prescription drug coverage

**THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE CERTIFICATE OF INSURANCE AND THE GROUP POLICY SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.**

Effective July 1, 2006

DEDUCTIBLES <sup>#</sup> (All providers combined)	Preferred Providers <sup>1</sup>	Non-Preferred Providers <sup>1</sup>
Calendar-year medical deductible	\$1,500 per member	
<b>Calendar-year Copayment Maximum<sup>#</sup></b>		Charges for non-emergency services received from non-preferred providers do not count toward the calendar-year copayment maximum and continue to be the member's responsibility
• Per individual	\$4,500 per member	
<b>LIFETIME MAXIMUMS</b>	\$6,000,000	
Covered Services	Member Copayment	
<b>PROFESSIONAL SERVICES</b>		
<b>Physician services</b>		
• Physician and specialist office visits (First 3 visits/calendar year) <sup>3</sup>	\$30/visit (Deductible waived)	50% (Deductible waived)
○ Subsequent visits after meeting the deductible <sup>3</sup>	30%	50%
• Laboratory and X-rays	30%	50%
• Allergy testing or treatment	30%	50%
• Diagnostic testing	30%	50%
<b>Preventive care</b> (Limited to \$250 per year maximum combined for all preventative care visits) <sup>*</sup>		
• Annual routine physical exam, eye/ear screenings and immunizations	\$30/visit (Deductible waived)	Not covered
• Laboratory, including mammogram and Pap test screening or other FDA-approved cervical cancer screening tests (One per calendar year)	30% (Deductible waived)	Not covered
<b>Well-baby care<sup>*</sup></b>		
• Office visits and consultations Includes: eye/ear screenings, immunizations, vaccinations	\$30/visit (Deductible waived)	Not covered
• Laboratory	30%	Not covered
<b>OUTPATIENT SERVICES</b>		
• Outpatient surgery in hospital/facility	\$500/surgery + 30%	50% <sup>4</sup>
• Outpatient treatment and necessary supplies	30%	50% <sup>4</sup>
<b>HOSPITALIZATION SERVICES</b>		
• Inpatient physician services (including pregnancy and maternity care)	30%	50%
• Semi-private room and board, medically necessary services and supplies	\$1,000/year + 30%	50% <sup>4</sup>
<b>Skilled nursing facility (SNF) services<sup>5</sup></b>		
(Combined maximum of up to 60 preauthorized days per calendar year; semi-private accommodations)		
• Freestanding SNF	30%	30%
• Hospital SNF unit	30%	50% <sup>4</sup>
<b>EMERGENCY HEALTH COVERAGE</b>		
• Facility services (Not resulting in a direct admission; deductible waived)	\$100 <sup>#</sup> + 30%	\$100 <sup>#</sup> + 30%
• Facility services (Resulting in a direct admission)	\$1,000/year + 30%	\$1,000/year + 30%
• Emergency room physician services	30%	30%
<b>AMBULANCE SERVICES</b>		
	30%	30%
<b>PRESCRIPTION DRUG COVERAGE<sup>*,#,6</sup></b> (including oral contraceptives, diaphragms, and covered diabetic drugs and testing supplies. 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 of the brand-name drug and its generic drug equivalent, as well as the applicable generic drug copay.)		
<b>Calendar-year Prescription Drug Coverage Maximum</b>	Maximum plan payment of \$500 brand-name drug benefit per member per calendar year (Combined maximum per calendar-year on brand-name retail and mail service drugs; after maximum is reached, member pays the Blue Shield Life Pharmacy network contracted rate.)	
• Retail prescriptions (For up to a 30-day supply)		
Generic drugs	\$15/prescription	Not covered

Covered Services	Member Copayment	
Formulary brand-name drugs	\$30 copay or 30% of Blue Shield Life contracted rate (whichever is greater)	Not covered
Non-formulary brand-name drugs	Not covered	Not covered
• Home self-administered injectable drugs (May require prior authorization from Blue Shield Pharmacy Services. Home self-administered injectable drugs are covered only when dispensed by select participating pharmacies in the Specialty Pharmacy Network. Drugs from non-participating pharmacies are not covered except in emergency and urgent situations.)	30%/prescription	Not covered
• Mail service prescriptions (For up to a 90-day supply)		
Generic drugs	\$30/prescription	Not covered
Formulary brand-name drugs	\$60 copay or 30% of Blue Shield Life contracted rate (whichever is greater)	Not covered
Non-formulary brand-name drugs	Not covered	Not covered
• Home self-administered injectable drugs	Not covered	Not covered
<b>DURABLE MEDICAL EQUIPMENT</b>	<b>Preferred Providers<sup>1</sup></b>	<b>Non-Preferred Providers<sup>1</sup></b>
• Home medical equipment, prosthetics/orthotics (Plan payment up to \$2,000 maximum per calendar year)	50%	Not covered
<b>MENTAL HEALTH SERVICES (PSYCHIATRIC)<sup>7</sup></b>	<b>MHSA Participating Providers<sup>1</sup></b>	<b>MHSA Non-Participating Providers<sup>1</sup></b>
• Inpatient hospital facility services	\$1,000/year + 30%	50% <sup>4</sup>
• Outpatient visits for severe mental health conditions (First 3 visits/calendar year) <sup>3</sup>	\$30/visit (Deductible waived)	50% (Deductible waived)
○ Subsequent visits after meeting the deductible <sup>3</sup>	30%	50%
• Outpatient visits for non-severe mental health conditions (Up to 20 visits per calendar year combined with outpatient chemical dependency visits) <sup>8</sup>	50% <sup>#</sup>	Not covered
<b>CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)<sup>7</sup>, PLEASE SEE FOOTNOTE 10</b>		
• Inpatient services for medical acute detoxification	\$1,000/year + 30%	50% <sup>4</sup>
• Outpatient visits (Up to 20 visits per calendar year combined with outpatient non-severe mental health visits) <sup>8</sup>	50% <sup>#</sup>	Not covered
<b>HOME HEALTH SERVICES</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 (For home self-administered injectables, see "Prescription Drug Coverage.")	30%	30% with prior authorization
<b>OTHER</b>		
<b>Hospice</b>		
• Routine home care and inpatient respite care	No charge	No charge with prior authorization
• 24 hour continuous home care and general inpatient care	30%	30% with prior authorization
<b>Alternative care<sup>2</sup></b>		
• Chiropractic services (Up to 12 visits per calendar year for any combination of physical therapy, occupational therapy, speech therapy, chiropractic services, and respiratory therapy)	30%	50%
• Acupuncture services	Not covered	Not covered
<b>Rehabilitative therapy services<sup>2</sup></b>		
• Outpatient visits (Up to 12 visits per calendar year for any combination of physical therapy, occupational therapy, speech therapy, chiropractic services, and respiratory therapy)	30%	50%
<b>Pregnancy and maternity care<sup>2</sup></b>		
• Prenatal and postnatal professional (physician) services (For all necessary inpatient hospital services, see "Hospitalization Services.")	30%	50%
<b>Family planning<sup>*2</sup></b>		
• Family planning counseling	30% (Deductible waived)	Not covered
• Elective abortion <sup>9</sup> , tubal ligation <sup>9</sup> , vasectomy <sup>9</sup>	30%	Not covered
<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.	30% or \$30 copay	50%
<b>Diabetes care</b>		
• Equipment, devices and non-testing supplies (For testing supplies, see "Prescription Drug Coverage")	50%	Not covered
• Self-management training and education (If billed by your provider, you will also be responsible for the office visit copayment) <sup>2</sup>	\$30/visit	50%
<b>Optional Benefits</b> Optional dental, vision or infertility benefit is 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 marked with a (#) do not accrue to 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.

continued on next page

- 1 Member is responsible for copayment in addition to any charges above allowable amounts. The coinsurance percentage indicated is a percentage of allowable amounts. Preferred providers accept Blue Shield of California Life & 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.
- 2 If billed by your provider, you will also be responsible for an office visit copayment or coinsurance. In addition, the office visit will count towards the first three visits.
- 3 For subsequent physician office visits, the member is responsible for 100 percent of the Allowable Amount up to the calendar-year medical deductible for Preferred Providers or MHA Participating Providers office visits, and for Non-Preferred Providers or MHA Non-Participating Providers office visits the member is responsible for billed charges (charges in excess of the Allowable Amount do not count towards the calendar-year medical deductible or out-of-pocket maximum). Once the calendar-year deductible has been met, the member is responsible for 30 percent of the Allowable Amount for Preferred Providers or MHA Participating Providers office visits up to the Calendar year out-of-pocket maximum and for Non-Preferred Providers or MHA Non-Participating Providers office visits the member is responsible for 50% of the Allowable Amount and any charges above the Allowable Amount. After the out-of-pocket maximum has been met, Blue Shield pays for 100% of the Allowable Amount for Preferred Providers or MHA Participating Providers and Non-Preferred Providers or MHA Non-Participating Providers office visits (the member continues to be responsible for charges in excess of the Allowable Amount billed by Non-Preferred Providers or MHA Non-Participating Providers).
- 4 The maximum allowed charges for non-emergency hospital services received from a non-preferred hospital is \$600 per day. Members are responsible for 50 percent of this \$600 per day, plus all charges in excess of \$600.
- 5 Services may require prior authorization by Blue Shield Life. When these services are prior authorized, members pay the preferred or participating provider level.
- 6 This plan's prescription drug coverage is less than the standard benefit set by the federal government for Medicare Part D (also called non-creditable coverage). For more information about drug coverage, call Customer Service at 1-888-852-5345.
- 7 Mental health and chemical dependency services, other than medical acute detoxification, are accessed through the mental health services administrator (MHA) – U.S. Behavioral Health Plan, California (USBHPC) – using MHA participating and non-participating providers. MHA non-participating providers are not administered by USBHPC. 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*.
- 8 All outpatient non-severe mental health, outpatient substance abuse accrue to the calendar-year visit maximum regardless of whether the plan deductible has been met.
- 9 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.
- 10 **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 by Blue Shield for subsequently enacted state or federal legislation. Please note if you switch to another Blue Shield of California and Blue Shield Life 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 is an overview of the plan benefits offered by Blue Shield of California Life & Health Insurance Company. ®BlueCard, Blue Shield and the Shield symbols are registered service marks of the BlueCross and BlueShield Association, an Association of Independent Blue Cross and Blue Shield Plans. Shield Spectrum PPO is a service mark of Blue Shield of California.

† Pending regulatory approval

