

Shield Spectrum PPOSM Plan 250 Premier

Benefit Summary

(Uniform Health Plan Benefits and Coverage Matrix)

Highlight: \$10/\$25/\$40 prescription drug coverage

Effective July 1, 2006

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND THE GROUP HEALTH SERVICE AGREEMENT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

DEDUCTIBLES[#] (All providers combined)	Preferred Providers¹	Non-Preferred Providers¹
Calendar-year medical deductible	\$250 per individual/\$500 per family	
Calendar-year Copayment Maximum[#]		
• Per individual/per family	\$2,000/\$4,000	\$10,000/\$20,000
LIFETIME MAXIMUMS	\$6,000,000	
Covered Services	Member Copayment	
PROFESSIONAL SERVICES		
Physician services		
Physician and specialist office visits	\$15/visit (Deductible waived)	30% [#]
• Laboratory and X-rays	\$15/visit	30%
• Allergy testing or treatment	10%	30%
• Diagnostic testing	10%	30%
Preventive care		
• Annual routine physical exam, eye/ear screenings and immunizations	\$15/visit (Deductible waived)	Not covered
• Laboratory, including mammogram and Pap test screening or other FDA-approved cervical cancer screening tests (One per calendar-year)	\$15/visit (Deductible waived)	Not covered
Well-baby care		
• Office visits and consultations Includes: eye/ear screenings, immunizations, vaccinations	\$15/visit (Deductible waived)	Not covered
• Laboratory	\$15/visit	Not covered
OUTPATIENT SERVICES		
• Outpatient surgery in hospital/facility	10%	30% ²
• Outpatient treatment and necessary supplies	10%	30% ^{2#}
HOSPITALIZATION SERVICES		
• Inpatient physician services (including pregnancy and maternity care)	10%	30%
• Semi-private room and board, medically necessary services and supplies	10%	30% ²
Skilled nursing facility (SNF) services³		
(Combined maximum of up to 100 preauthorized days per calendar-year; semi-private accommodations)		
• Freestanding SNF	10%	10%
• Hospital SNF unit	10%	30% ²
EMERGENCY HEALTH COVERAGE		
• Facility services (Not resulting in a direct admission; deductible waived)	\$50 [#] + 10%	\$50 [#] + 10%
• Facility services (Resulting in a direct admission)	10%	10%
• Emergency room physician services	10%	10%
AMBULANCE SERVICES		
PRESCRIPTION DRUG COVERAGE^{#,4} (DEDUCTIBLE WAIVED)		
(Including oral contraceptives, diaphragms, and covered diabetic drugs and testing supplies)		
Note: 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 of the brand-name drug and its generic drug equivalent, as well as the applicable generic drug copayment.		
Participating Pharmacy		
Non-Participating Pharmacy		
Member pays 25% of allowed charge plus a copayment of:		
• Retail prescriptions (For up to a 30-day supply)		
Generic drugs	\$10/prescription	\$10/prescription
Formulary brand-name drugs	\$25/prescription	\$25/prescription
Non-formulary brand-name drugs	\$40/prescription	\$40/prescription
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	\$20/prescription	Not covered
Formulary brand-name drugs	\$50/prescription	Not covered
Non-formulary brand-name drugs	\$80/prescription	Not covered
Home self-administered injectable drugs	Not covered	Not covered

Covered Services

Member Copayment

DURABLE MEDICAL EQUIPMENT

- Home medical equipment, prosthetics/orthotics (Orthosis benefits, except for services covered under diabetes care, are limited to a \$2,000 maximum per person per calendar-year)

Preferred
Providers¹
10%

Non-Preferred
Providers¹
30%

MENTAL HEALTH SERVICES (PSYCHIATRIC)⁵

- Inpatient hospital facility services
- Outpatient visits for severe mental health conditions
- Outpatient visits for non-severe mental health conditions
(Up to 20 visits per calendar-year combined with outpatient chemical dependency visits)⁶

MHSA
Participating
Providers¹
10%
\$15/visit (Deductible waived)
\$25/visit[#]

MHSA Non-
Participating
Providers¹
30%²
30%[#]
Not covered

CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)⁵,

Please see footnote 8

- Inpatient services for medical acute detoxification
- Outpatient visits
(Up to 20 visits per calendar-year combined with outpatient non-severe mental health visits)⁶

10%
\$25/visit[#]

30%²
Not covered

HOME HEALTH SERVICES (Combined maximum of 100 prior authorized visits per calendar-year)

- Home health and home infusion care
(For home self-administered injectables, see "Prescription Drug Coverage")

Preferred
Providers¹
10%

Non-Preferred
Providers¹
10% with prior
authorization

OTHER

Hospice

- Routine home care and inpatient respite care
- 24 hour continuous home care and general inpatient care

No charge

No charge with
prior authorization³
10% with prior
authorization³

Alternative care⁶

- Chiropractic services (Up to 12 visits per calendar-year)
- Acupuncture services (Up to 20 visits per calendar-year)

\$25/visit
\$25/visit

30%
\$25/visit

Rehabilitative therapy services

- Outpatient visits

\$25/visit

30%

Pregnancy and maternity care

- Prenatal and postnatal professional (physician) services
(For all necessary inpatient hospital services, see "Hospitalization Services.")

10%

30%

Family planning

- Family planning counseling
- Elective abortion⁷, tubal ligation⁷, vasectomy⁷

\$15/visit (Deductible waived)
10%

Not covered
Not covered

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.

10% or \$15 copay

30%

Diabetes care

- Equipment, devices and non-testing supplies
(For testing supplies, see "Prescription Drug Coverage.")
- Self-management training and education (If billed by your provider, you will also be responsible for the office visit copayment)

10%

30%

\$15/visit

30%

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.

Deductible and 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 *Evidence of Coverage* and the *Group Health Service Agreement* for exact terms and conditions of coverage.

- 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.
- 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.
- Services may require prior authorization by Blue Shield. When these services are prior authorized, members pay the preferred or participating provider level.
- 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).
- Mental health and chemical dependency services, other than medical acute detoxification, are accessed through the mental health services administrator (MHSA) – U.S. Behavioral Health Plan, California (USBHPC) – using MHSA participating and non-participating providers. MHSA non-participating providers are not administered by USBHPC. 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.
- 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.
- 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.
- 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."**

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