

Shield Spectrum PPOSM Plan 3000

Benefit Summary

Highlights: \$500 brand-name drug deductible,
\$15/\$30/\$45 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

	Preferred Providers ¹	Non-Preferred Providers ¹
DEDUCTIBLES[#] (All providers combined)		
Calendar-year medical deductible	\$3,000 per individual/\$6,000 per family	
Calendar-year Copayment Maximum[#]		
• Per individual/per family	\$6,000/\$12,000	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
LIFETIME MAXIMUMS	\$6,000,000	
Covered Services	Member Copayment	
PROFESSIONAL SERVICES		
Physician services		
• Physician and specialist office visits	20% (Deductible waived)	50%
• Laboratory and X-rays	20%	50%
• Allergy testing or treatment	20%	50%
• Diagnostic testing	20%	50%
Preventive care		
• Annual routine physical exam, eye/ear screenings and immunizations	\$45/visit (Deductible waived)	Not covered
• Laboratory, including mammogram and Pap test screening or other FDA-approved cervical cancer screening tests (One per calendar-year)	\$45/visit (Deductible waived)	Not covered
Well-baby care		
• Office visits and consultations Includes: eye/ear screenings, immunizations, vaccinations	\$45/visit (Deductible waived)	Not covered
• Laboratory	\$45/visit	Not covered
OUTPATIENT SERVICES		
• Outpatient surgery in hospital/facility	\$250/surgery [#] + 20%	50% ²
• Outpatient treatment and necessary supplies	20%	50% ²
HOSPITALIZATION SERVICES		
• Inpatient physician services (including pregnancy and maternity care)	20%	50%
• Semi-private room and board, medically necessary services and supplies	\$500/year + 20%	50% ²
Skilled nursing facility (SNF) services³ (Combined maximum of up to 60 preauthorized days per calendar-year; semi-private accommodations)		
• Freestanding SNF	20%	20%
• Hospital SNF unit	20%	50% ²
EMERGENCY HEALTH COVERAGE		
• Facility services (Not resulting in a direct admission; deductible waived)	\$100 [#] + 20%	\$100 [#] + 20%
• Facility services (Resulting in a direct admission)	\$500/year + 20%	\$500/year + 20%
• Emergency room physician services	20%	20%
AMBULANCE SERVICES	20%	20%
PRESCRIPTION DRUG COVERAGE^{*,#,#,4} (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 the brand-name drug and its generic drug equivalent, as well as the applicable generic drug copayment.	Participating Pharmacy	Non-Participating Pharmacy
• Calendar-year Brand-Name Drug Deductible	\$500 per member applies to all covered brand-name and home self-administered injectable drugs.	
• Retail prescriptions (For up to a 30-day supply)		
Generic drugs	\$15/prescription	Not covered
Formulary brand-name drugs	\$30/prescription	Not covered
Non-formulary brand-name drugs	\$45/prescription	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/prescription	Not covered
Non-formulary brand-name drugs	\$90/prescription	Not covered
Home self-administered injectable drugs	Not covered	Not covered

Covered Services

Member Copayment

DURABLE MEDICAL EQUIPMENT

- Home medical equipment, prosthetics/orthotics (Plan payment up to \$2,000 maximum per calendar-year)

Preferred
Providers¹
50%

Non-Preferred
Providers¹
Not covered

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
\$500/year + 20%
20% (Deductible waived)
\$45/visit[#]

MHSA Non-
Participating Providers¹
50%²
50%
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

\$500/year + 20%
\$45/visit[#]

50%²
Not covered

HOME HEALTH SERVICES

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

- Home health and home infusion care (See "Prescription Drug Coverage" for home self-administered injectables. Not covered through Mail Service.)

Preferred
Providers¹
20%

Non-Preferred
Providers¹
20% with prior
authorization

OTHER

Hospice

- Routine home care and inpatient respite care

No charge

No charge with prior
authorization

- 24 hour continuous home care and general inpatient care

20%

20% with prior authorization

Rehabilitative therapy services

- Outpatient visits (Up to 12 visits per calendar-year for any combination of physical therapy, occupational therapy, speech therapy, chiropractic services, and respiratory therapy)

20%

50%

Pregnancy and maternity care

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

20%

50%

Family planning

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

20% (Deductible waived)
20%

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.

20% or \$45 copay

50%

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)

50%

Not covered

\$45/visit

50%

Optional Benefits 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.

Deductible and copayments marked with a (#) do not accrue to calendar-year copayment maximum. Copayments and charges for services are not accruing to the member's calendar-year copayment maximum and 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.

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 Life'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 for emergency services from preferred and non-preferred providers count toward the preferred provider calendar-year copayment maximum. Charges for non-emergency services received from non-preferred providers do not count toward the calendar-year copayment maximum and continue to be the members' responsibility.

2 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.

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

4 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).

5 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 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*.

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

7 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.

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 by Blue Shield for subsequently enacted state or federal legislation. Please note that if you switch to another Blue Shield of California or Blue Shield of California Life & Health Insurance Company plan, your prescription drug deductible credit from your previous plan, 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 marks of the BlueCross BlueShield Association, an Association of Independent Blue Cross and Blue Shield Plans. Shield Spectrum PPO is a service mark of Blue Shield of California.

