

Shield Spectrum PPOSM Plan 500 Premier

Benefit Summary

(Uniform Health Plan Benefits and Coverage Matrix)

Highlights: \$150 brand-name drug deductible,
\$10/\$25/\$40 prescription drug coverage

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.

Effective July 1, 2006

DEDUCTIBLES[#] (All providers combined)

Calendar-year medical deductible

Preferred Providers ¹	Non-Preferred Providers ¹
\$500 per individual/\$1,000 per family	

Calendar-year Copayment Maximum[#]

- Per individual/per family

\$3,500/\$7,000	\$10,000/\$20,000
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LIFETIME MAXIMUMS

\$6,000,000

Covered Services

Member Copayment

PROFESSIONAL SERVICES

Physician services

- Physician and specialist office visits
- Laboratory and X-rays
- Allergy testing or treatment
- Diagnostic testing

\$35/visit (Deductible waived)	40% [#]
\$35/visit	40%
20%	40%
20%	40%

Preventive care

- Annual routine physical exam, eye/ear screenings and immunizations
- Laboratory, including mammogram and Pap test screening or other FDA-approved cervical cancer screening tests (One per calendar-year)

\$35/visit (Deductible waived)	Not covered
\$35/visit (Deductible waived)	Not covered

Well-baby care

- Office visits and consultations Includes: eye/ear screenings, immunizations, vaccinations
- Laboratory

\$35/visit (Deductible waived)	Not covered
\$35/visit	Not covered

OUTPATIENT SERVICES

- Outpatient surgery in hospital/facility
- Outpatient treatment and necessary supplies

20%	40% ²
20%	40% ^{2#}

HOSPITALIZATION SERVICES

- Inpatient physician services (including pregnancy and maternity care)
- Semi-private room and board, medically necessary services and supplies

20%	40%
20%	40% ²

Skilled nursing facility (SNF) services³

(Combined maximum of up to 100 preauthorized days per calendar-year; semi-private accommodations)

- Freestanding SNF
- Hospital SNF unit

20%	20%
20%	40% ²

EMERGENCY HEALTH COVERAGE

- Facility services (Not resulting in a direct admission; deductible waived)
- Facility services (Resulting in a direct admission)
- Emergency room physician services

\$100 [#] + 20%	\$100 [#] + 20%
20%	20%
20%	20%

AMBULANCE SERVICES

20%	20%
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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 California of the brand-name drug and its generic drug equivalent, as well as the applicable generic drug copayment.

Calendar-year brand-name drug deductible

\$150 per member per calendar-year; applies to all covered brand-name and home self-administered injectable drugs.

- Retail prescriptions (For up to a 30-day supply)

Generic drugs
Formulary brand-name drugs
Non-formulary brand-name drugs

Participating Pharmacy	Non-Participating Pharmacy
\$10/prescription	\$10/prescription
\$25/prescription	\$25/prescription
\$40/prescription	\$40/prescription
30%/prescription	Not covered

Member pays 25% of allowed charge plus a copayment of:

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.)

- Mail service prescriptions (For up to a 90-day supply)

Generic drugs
Formulary brand-name drugs
Non-formulary brand-name drugs
Home self-administered injectable drugs

\$20/prescription	Not covered
\$50/prescription	Not covered
\$80/prescription	Not covered
Not covered	Not covered

Not covered
Not covered
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
50%

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
20%
\$35/visit (Deductible waived)
\$25/visit[#]

MHSA Non-Participating Providers¹
40%²
40%[#]
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

20%
\$25/visit[#]

40%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
20%

Non-Preferred Providers¹
20% with prior authorization

OTHER

Hospice

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

No charge
20%

No charge with prior authorization
20% with prior authorization

Alternative care⁶

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

\$25/visit
Not covered

40%
Not covered

Rehabilitative therapy services

- Outpatient visits

\$35/visit

40%

Pregnancy and maternity care

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

20%

40%

Family planning

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

\$35/visit (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 \$35 copay

40%

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%

50%

\$35/visit

40%

Optional Benefits Optional dental, vision, inpatient substance abuse treatment, 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.

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 40 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 amount.
- 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 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."**

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 the previous plan during the calendar-year, if applicable, will not carry forward to your new plan. 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.

