

# Shield Spectrum PPO<sup>SM</sup> Plan, Zero Deductible

## Benefit Summary

(Uniform Health Plan Benefits and Coverage Matrix)

Highlights: \$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.**

<b>DEDUCTIBLES<sup>#</sup></b>	<b>Preferred Providers<sup>1</sup></b>	<b>Non-Preferred Providers<sup>1</sup></b>
Calendar-year medical deductible		
• Per individual/per family	None	\$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	
<b>Covered Services</b>	<b>Member Copayment</b>	
<b>PROFESSIONAL SERVICES</b>		
<b>Physician services</b>		
• Physician and specialist office visits	\$10/visit (Deductible waived)	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 routine physical exam, eye/ear screenings and immunizations	\$10/visit (Deductible waived)	Not covered
• Laboratory, including mammogram and Pap test screening or other FDA-approved cervical cancer screening tests (One per calendar-year)	\$10/visit (Deductible waived)	Not covered
<b>Well-baby care</b>		
• Office visits and consultations Includes: eye/ear screenings, immunizations, vaccinations	\$10/visit (Deductible waived)	Not covered
• Laboratory	\$10/visit	Not covered
<b>OUTPATIENT SERVICES</b>		
• Outpatient surgery in hospital/facility	10%	30% <sup>2</sup>
• Outpatient treatment and necessary supplies	10%	30% <sup>2#</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%	30% <sup>2</sup>
<b>Skilled nursing facility (SNF) services<sup>3</sup></b> (Combined maximum of up to 100 preauthorized days per calendar-year; semi-private accommodations)		
• Freestanding SNF	10%	10%
• Hospital SNF unit	10%	30% <sup>2</sup>
<b>EMERGENCY HEALTH COVERAGE</b>		
• Facility services (Not resulting in a direct admission; deductible waived)	\$50 <sup>#</sup> + 10%	\$50 <sup>#</sup> + 10%
• Facility services (Resulting in a direct admission)	10%	10%
• Emergency room physician services	10%	10%
<b>AMBULANCE SERVICES</b>		
	10%	10%
<b>PRESCRIPTION DRUG COVERAGE<sup>#,4</sup> (DEDUCTIBLE WAIVED)</b>		
<small>(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.</small>		
• 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 <small>(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.)</small>	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  
Providers<sup>1</sup>  
10%

Non-Preferred  
Providers<sup>1</sup>  
30%

### MENTAL HEALTH SERVICES (PSYCHIATRIC)<sup>5</sup>

- 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)<sup>6</sup>

MHSA  
Participating  
Providers<sup>1</sup>  
10%  
\$10/visit (Deductible waived)  
\$25/visit<sup>#</sup>

MHSA Non-  
Participating  
Providers<sup>1</sup>  
30%<sup>2</sup>  
30%<sup>#</sup>  
Not covered

### CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)<sup>5</sup>, 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)<sup>6</sup>

10%  
\$25/visit<sup>#</sup>

30%<sup>2</sup>  
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  
Providers<sup>1</sup>  
10%

Non-Preferred  
Providers<sup>1</sup>  
10% with prior  
authorization

### OTHER

#### Hospice

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

No charge  
10%

No charge with prior  
authorization  
10% with prior  
authorization

#### Alternative care<sup>6</sup>

- 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 abortion<sup>7</sup>, tubal ligation<sup>7</sup>, vasectomy<sup>7</sup>

\$10/visit (Deductible waived)  
10%<sup>2</sup>

Not covered  
Not covered

**Covered out-of-state benefits** 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.

10% or \$10 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%

\$10/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."**

Benefits are subject to modification by Blue Shield for subsequently enacted state or federal legislation. <sup>®</sup>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.

