

Shield Spectrum PPO Savings Plans 2400 (Individual)/4800 (Family) and 4000 (Individual)/8000 (Family)

Uniform health plan benefits and coverage matrix

Effective February 1, 2007

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The *Evidence of Coverage (EOC)/Policy for Individuals and Families* should be consulted for a detailed description of coverage benefits and limitations.

Shield Spectrum PPOSM Savings Plans

	2400/4800	4000/8000
Deductible*	\$2,400 (\$4,800 family)	\$4,000 (\$8,000 family)
Percentage copayment/ coinsurance	30% with preferred providers 50% with non-preferred providers	No charge after deductible with preferred providers 50% with non-preferred providers
Calendar-year out-of-pocket maximum (includes the plan deductible)	\$3,200 (\$5,800 family)	Services with preferred providers: \$4,000 (\$8,000 family) Services with all providers: \$5,000 (\$10,000 family)
Lifetime maximum	\$6,000,000	\$6,000,000

Shield Spectrum PPO Savings Plan 4000/8000 is underwritten by Blue Shield of California Life & Health Insurance Company.

Please note: The deductibles and out-of-pocket maximum amounts may increase annually to reflect federal cost-of-living adjustment.

* For two-party/family coverage: Only after the family deductible is met will any individual be eligible for benefits. Adds together applicable expenses accrued by all covered family members.

- In benefits provided before you need to meet any medical deductible are shown below with a blue dot. For all benefits without a dot, you are responsible for all charges up to the allowable amount or billed charges with preferred and non-preferred providers until the deductible is met. At that point, you will be responsible for the copayment or coinsurance noted in the chart below when accessing preferred and non-preferred providers.

Covered services

Member copayments

	With preferred providers ¹		With non-preferred providers ¹
	2400/4800	4000/8000	
Professional services			
Office visits	30%	No charge after deductible	50%
Preventive care			
Annual routine physical exam, gynecological exam, well-baby care office visits	\$35 ●	\$35 (no charge after deductible) ●	Not covered
Annual Pap test or other approved cervical cancer screening tests and routine mammography, immunizations (with annual physical or in a separate office visit)	30% ●	30% (no charge after deductible) ●	Not covered
Outpatient services (The maximum allowed charges for non-emergency surgery and services performed in a non-participating ambulatory surgery center is \$300 per day. Members are responsible for 50% of this \$300 per day, plus all charges in excess of \$300.)			
Non-emergency services and procedures, outpatient surgery in a hospital	30%	No charge after deductible	50% ²
Outpatient surgery performed in an ambulatory surgery center (ASC) ⁴	30%	No charge after deductible	50% ²
Outpatient X-ray and laboratory	30%	No charge after deductible	50%
Hospitalization services			
Inpatient physician visits and consultations, surgeons and assistants, and anesthesiologists	30%	No charge after deductible	50%
Inpatient semiprivate room and board, services and supplies, and subacute care	30%	No charge after deductible	50% ²
Bariatric surgery inpatient services (pre-authorization required: medically necessary surgery for weight loss, only for morbid obesity) ⁵	30%	No charge after deductible	50% ²
Emergency health coverage			
Emergency room services (\$75 copayment waived if the member is admitted directly to the hospital as an inpatient)	\$75/visit + 30%	No charge after deductible	Covered at same level as preferred provider
ER physician visits	30%	No charge after deductible	Covered at same level as preferred provider
Ambulance services (surface or air)	30%	No charge after deductible	Covered at same level as preferred provider
	At participating and non-participating pharmacies (up to a 30-day supply)		Mail-service prescriptions (up to a 60-day supply)
	2400/4800	4000/8000	2400/4800 and 4000/8000
Prescription drug coverage³ (outpatient: subject to the plan medical deductible)	30%	No charge after deductible	Covered at same level as participating and non-participating pharmacies
	With preferred providers¹		With non-preferred providers¹
	2400/4800	4000/8000	
Durable medical equipment⁶	30%	No charge	50%

Covered services

Member copayments

	With MHSA participating providers ^{1,7}		With MHSA non-participating providers ^{1,7}
	2400/4800	4000/8000	
Mental health services			
Inpatient hospital facility services	30%	No charge after deductible	50% ²
Inpatient physician services, outpatient visits for severe mental health conditions	30%	No charge after deductible	50%
Outpatient visits for non-severe mental health conditions (up to 20 visits per calendar year combined with chemical dependency visits)	30%	No charge after deductible	Not covered
Chemical dependency services (substance abuse)			
Inpatient hospital facility services for medical acute detoxification	30%	No charge after deductible	50% ²
Inpatient physician services for medical acute detoxification	30%	No charge after deductible	50%
Outpatient visits (up to 20 visits per calendar year combined with non-severe mental health visits)	30%	No charge after deductible	Not covered
	With preferred providers¹		With non-preferred providers¹
Home health services (up to 90 pre-authorized visits per calendar year)	30%	No charge after deductible	Not covered
Other			
Pregnancy and maternity care			
Outpatient prenatal and postnatal care	30%	Not covered	50% (not covered for PPO Savings Plan 4000/8000)
Delivery and all necessary inpatient hospital services	30%	Not covered	50% ² (not covered for PPO Savings Plan 4000/8000)
Family planning			
Consultations, tubal ligation, vasectomy, elective abortion	30%	No charge after deductible	Not covered
Rehabilitation services			
Provided in the office of a physician or physical, occupational, or respiratory therapist	30%	No charge after deductible	50%
Chiropractic services (up to 12 visits per calendar year; member is responsible for all charges over \$25/visit)	50% up to \$25	No charge after deductible	Not covered
Out-of-state services (full plan benefits covered nationwide with the BlueCard® Program)	30% with BlueCard participating providers	No charge after deductible with BlueCard participating providers	50% with all other providers

Please note: Benefits are subject to modification for subsequently enacted state or federal legislation.

- Plan benefits provided before you need to meet the medical deductible.
- 1 Member is responsible for fixed dollar or percentage copayment, in addition to any charges above allowable amounts. The copayment percentage indicated is a percentage of the allowed amounts. Preferred providers accept Blue Shield's allowable amount as payment-in-full for covered services. Non-preferred providers can charge more than the allowable amounts. When members use non-preferred providers, they must pay the applicable copayment plus any charges that exceed Blue Shield's allowable amount. Charges above the allowable amount do not count toward the plan deductible or the calendar year out-of-pocket maximum.
 - 2 For non-emergency hospital services and supplies received from a non-preferred (non-network) hospital, Blue Shield's maximum payment is \$300 per day. After the deductible is met, members are responsible for all charges that exceed \$300 per day.
 - 3 Member pays full price and submits prescription drug claims to Blue Shield. Prescription coverage differs for home self-injectables. Please review the EOC/Policy before you purchase the plan.
 - 4 Participating ambulatory surgery centers may not be available in all areas. Regardless of their availability, you can obtain outpatient surgery services from a hospital, or an ambulatory surgery center affiliated with a hospital with payment according to your health plan's hospital services benefits.
 - 5 Bariatric surgery is covered when pre-authorized by Blue Shield. However, for members residing in Imperial, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Barbara and Ventura counties ("designated counties"), bariatric surgery services are covered only when performed at designated contracting bariatric surgery facilities and by designated contracting surgeons; coverage is not available for bariatric services from any other preferred provider and there is no coverage for bariatric services from non-preferred providers. In addition, if prior authorized by Blue Shield, a member in a designated county who is required to travel more than 50 miles to a designated bariatric surgery facility will be eligible for limited reimbursement for specified travel expenses for the member and one companion. Refer to the EOC/Policy for further benefit details.
 - 6 For PPO Savings Plan 2400/4800, all covered orthotic equipment and services have a benefit maximum of \$2,000 per member per calendar year, except those services covered under the prosthetic appliances, durable medical equipment or the diabetes care benefit. For PPO Savings Plan 4000/8000, all covered durable medical equipment, prosthetic, and orthotic equipment and services have a combined benefit maximum of \$2,000 per member per calendar year, except those services covered under the diabetes care benefit.
 - 7 Blue Shield has contracted with a specialized health care service plan to act as our mental health services administrator (MHSA). The MHSA provides mental health and chemical dependency services, other than inpatient services for medical acute detoxification, through a separate network of MHSA participating providers. Inpatient medical acute detoxification is a medical benefit provided by Blue Shield preferred or non-preferred (not MHSA) providers.