



# Shield Spectrum PPO Plan 5000

## Uniform Health Plan Benefits & Coverage Matrix

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE CERTIFICATE OF INSURANCE AND POLICY SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Plan benefits that are available before you need to meet the medical plan deductible are shown below in a shaded box. For all boxes without shading, you are responsible for all charges up to the allowable amount or billed charges 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. **Please note:** Preferred hospitals are designated as either **Choice** or **Affiliate**, and different copayments may apply. Please see the Glossary for descriptions of **Choice** and **Affiliate** Hospitals.

| SHIELD SPECTRUM PPO PLAN 5000   |  |
|---|--|
| This plan is underwritten by Blue Shield of California Life & Health Insurance Company.   |  |
| DEDUCTIBLE*   | \$5,000 (\$10,000 Family)  |
| COPAYMENTS  | \$35 with Preferred Providers<br>Not applicable with Non-Preferred Providers   |
| COINSURANCE   | 30% with Preferred <b>Choice</b> Hospitals<br>40% with Preferred <b>Affiliate</b> Hospitals<br>50% with Non-Preferred Providers          |
| CALENDAR-YEAR COPAYMENT/COINSURANCE MAXIMUM (Includes the plan deductible. Some services do not apply.)   | Services with Preferred <b>Choice</b> Providers **: \$7,000 (\$14,000 Family)<br>Services with All Providers: \$10,000 (\$20,000 Family) |
| LIFETIME MAXIMUM  | \$6,000,000  |
| CRITICAL CONDITION PROTECTION   | \$10,000 per member, per lifetime  |
| * Benefits for covered brand-name drugs are subject to a separate \$500 brand-name drug deductible per person.  |  |
| ** This copayment/coinsurance maximum also includes copayments or coinsurance for services from preferred providers when there is no designation of "Choice Hospital" and "Affiliate Hospital." |  |

| COVERED SERVICES<br>(Subject to the plan deductible, unless noted)  | MEMBER COPAYMENTS                              |  |
|---|--|--|
|   | With Preferred Providers, <sup>1</sup> you pay | With Non-Preferred Providers, <sup>1</sup> you pay |
| <b>PROFESSIONAL SERVICES</b>  |  |  |
| – Office visits, consultations, OB/GYN and specialist visits, second surgical opinions, urgent care services, asthma self-management training   | \$35   | 50%  |
| – Allergy testing and treatment   | 30%  | 50%  |
| <b>PREVENTIVE CARE</b>  |  |  |
| – Annual Routine Physical Exam, Well-Baby care office visits, and Gynecological exam office visit (includes Pap test or other approved cervical cancer screening tests, routine mammography, and immunizations when received as part of the annual exam or preventive care visit) | \$35   | Not Covered  |
| <b>OUTPATIENT SERVICES</b>  |  |  |
| – Non-Emergency services and procedures, Outpatient surgery in a hospital   | 30%<br>w/ Choice Hospitals                     | 40%<br>w/ Affiliate Hospitals                      |
| – Outpatient or Out-of-Hospital X-ray and Laboratory  | 30%  | 50% <sup>2,3</sup>                                 |
| – Non-Emergency surgery in an Ambulatory Surgery Center (ASC)   | 30%  | 50% <sup>2,3</sup>                                 |
| – Radiological Procedure requiring prior authorization (such as CT scans, MRIs, MRAs, PET scans, Bone Densitometry and any cardiac diagnostic procedure utilizing Nuclear Medicine)   | 30%  | 50%  |

**COVERED SERVICES****MEMBER COPAYMENTS**

(Subject to the plan deductible, unless noted)

**With Preferred Providers,<sup>1</sup> you pay****With Non-Preferred Providers,<sup>1</sup> you pay****HOSPITALIZATION SERVICES**

|  |                            |                               |
|--|----------------------------|-------------------------------|
| – Inpatient physician visits and consultations, surgeons and assistants, and anesthesiologists | 30%                        | 50%                           |
| – Inpatient semiprivate room and board, services and supplies, and subacute care               | 30%<br>w/ Choice Hospitals | 40%<br>w/ Affiliate Hospitals |
|  |                            | 50% <sup>2,3</sup>            |

**EMERGENCY HEALTH COVERAGE**

|  |           |           |
|--|-----------|-----------|
| – Outpatient Emergency room facility services, semiprivate room and board, services and supplies, and subacute care not resulting in admission | 30%/visit | 30%/visit |
| – ER Physician visits <sup>4</sup>   | 30%       | 30%       |

**AMBULANCE SERVICES** (Surface or Air)<sup>5</sup>

30%

30%

**PRESCRIPTION DRUG COVERAGE<sup>6</sup>**

(outpatient; brand-name drugs are subject to a \$500 brand-name drug deductible per person, per calendar year; includes oral contraceptives, diaphragms, diabetic testing supplies, asthma inhalers and inhaler spacers)

**At Participating Pharmacies**  
(Up to a 30-day supply)**Mail Service Prescriptions**  
(Up to a 60-day supply)

|   |  |   |
|---|--|---|
| – Generic formulary drugs                         | \$10/prescription <sup>2</sup>   | \$20/prescription <sup>2</sup>  |
| – Formulary brand-name drugs <sup>4,7</sup>       | \$30+10%/prescription<br>(maximum copayment of \$60 per prescription) <sup>2</sup> | \$60+10%/prescription<br>(maximum copayment of \$150 per prescription) <sup>2</sup> |
| – Non-formulary brand-name drugs <sup>4,7</sup>   | \$45 or 50%/prescription<br>(whichever is greater) <sup>2</sup>                    | \$75 or 50%/prescription<br>(whichever is greater) <sup>2</sup>                     |
| – Home Self-Administered Injectables <sup>8</sup> | 30% <sup>2</sup>   | Not Covered   |

**DURABLE MEDICAL EQUIPMENT**

|  |     |     |
|--|-----|-----|
| – Prosthetic Appliances, Home Medical Equipment, Asthma Nebulizers (including face masks and tubing), Peak Flow Monitors and Orthotic Equipment <sup>9</sup> | 30% | 50% |
|--|-----|-----|

**With MHA Participating Providers,<sup>1</sup> you pay****With MHA Non-Participating Providers,<sup>1</sup> you pay****MENTAL HEALTH SERVICES<sup>10,11</sup>**

|  |      |                    |
|--|------|--------------------|
| – Inpatient Hospital Facility Services   | 30%  | 50% <sup>2,3</sup> |
| – Inpatient Physician Services   | 30%  | 50%                |
| – Outpatient visits for severe mental health conditions  | \$35 | 50%                |
| – Outpatient visits for non-severe mental health conditions (up to 20 visits per calendar year combined with chemical dependency visits) | 30%  | Not Covered        |

**CHEMICAL DEPENDENCY SERVICES**(Substance Abuse)<sup>11</sup>

|   |                            |                               |                    |
|---|----------------------------|-------------------------------|--------------------|
| – Inpatient Hospital Facility Services for medical acute detoxification                               | 30%<br>w/ Choice Hospitals | 40%<br>w/ Affiliate Hospitals | 50% <sup>2,3</sup> |
| – Inpatient Physician Services for medical acute detoxification                                       | 30%                        |                               | 50%                |
| – Outpatient visits (up to 20 visits per calendar year combined with non-severe mental health visits) | 30%                        |                               | Not Covered        |

**With Preferred Providers,<sup>1</sup> you pay****With Non-Preferred Providers,<sup>1</sup> you pay****HOME HEALTH SERVICES**

(Up to 90 preauthorized visits per calendar year)

30%

Not Covered

**COVERED SERVICES**
**MEMBER COPAYMENTS**

(Subject to the plan deductible, unless noted)

 With Preferred Providers,<sup>1</sup> you pay

 With Non-Preferred Providers,<sup>1</sup> you pay

**OTHER**
**Pregnancy and Maternity Care<sup>12</sup>**

|  |                            |                               |                    |
|--|----------------------------|-------------------------------|--------------------|
| – Outpatient prenatal and postnatal care                 | 30%                        | 50%                           |                    |
| – Delivery and all necessary inpatient hospital services | 30%<br>w/ Choice Hospitals | 40%<br>w/ Affiliate Hospitals | 50% <sup>2,3</sup> |

**Family Planning**

|   |                   |             |
|---|-------------------|-------------|
| – Consultations, tubal ligation, vasectomy, elective abortion | 30%               | Not Covered |
| – Injectable Contraceptives <sup>13</sup>                     | \$25 <sup>2</sup> | Not Covered |

**Rehabilitation Services**

(up to 12 visits per calendar year combined with Speech Therapy visits)

|   |     |     |
|---|-----|-----|
| – Physical, occupational, or respiratory therapy received in a provider's office or outpatient department of a hospital | 30% | 50% |
|---|-----|-----|

**Speech Therapy**

(up to 12 visits per calendar year combined with Rehabilitation Services visits)

|  |     |     |
|--|-----|-----|
| – Received in a provider's office or outpatient department of a hospital | 30% | 50% |
| – Received from a licensed speech therapist                              | 30% | 30% |

**Skilled Nursing Facility (SNF) and Subacute Care**

(semiprivate accommodations following transfer from hospital unless Blue Shield gives written authorization; up to 100 days per calendar year)

30% in hospital or freestanding SNF

 50%<sup>2</sup> in hospital SNF  
30% in freestanding SNF

**Out-of-State Services**

(full plan benefits covered nationwide with the BlueCard program)

30% with BlueCard Participating Providers

50% with all other providers

**Diabetes Care**

|                                     |      |     |
|-------------------------------------|------|-----|
| – Diabetes Self-Management Training | \$35 | 50% |
| – Diabetes Care Supplies            | 30%  | 50% |

**Dental Services and Life Insurance (Optional dental benefits and life insurance are available.)**
**Please Note:** Benefits are subject to modification for subsequently enacted state or federal legislation.

‡ The brand-name drug deductible is separate from the medical plan deductible.

- 1 Member is responsible for copayment or coinsurance in addition to any charges above allowable amounts. The coinsurance indicated is a percentage of the allowable amounts. Preferred providers accept Blue Shield allowable amounts as payment-in-full for covered services. Non-preferred providers can charge more than these amounts. When members use non-preferred providers, they must pay the applicable copayment or coinsurance plus any charges that exceed Blue Shield's allowable amount. Charges above the allowable amount do not count toward the plan deductible or copayment/coinsurance maximum. Mental health and chemical dependency services, other than services for medical acute detoxification, are accessed through the mental health services administrator (MHSA) utilizing MHSA participating providers. MHSA participating providers agree to accept the MHSA's payment, plus Member's payment of any applicable deductible, copayment, coinsurance or amounts in excess of benefit dollar maximums specified, as payment-in-full for covered mental health and substance abuse services. Inpatient services for medical acute detoxification are accessed through Blue Shield utilizing Blue Shield's preferred and non-preferred (not MHSA) providers.
- 2 These copayments or coinsurance do not count toward the copayment/coinsurance maximum and will continue to be charged once it is reached.
- 3 For non-emergency hospital services and supplies received from a non-preferred hospital, Blue Shield's payment is limited to \$250 per day. Members are responsible for all charges that exceed \$250 per day.
- 4 Members pay the preferred provider percentage copayment level, 30 percent, for physician services received during an emergency room visit.
- 5 Members who reasonably believe that they have an emergency medical condition which requires an emergency response are encouraged to appropriately use the 911 emergency response system where available.
- 6 The drug formulary is a comprehensive list of recommended drugs, based on safety, efficacy, FDA bioequivalency and cost-effectiveness, and is reviewed and updated four times per year. Always present your Blue Shield ID card to obtain benefits at a participating (network) pharmacy. Except for covered emergencies, prescription drugs obtained from non-participating pharmacies are not covered. Call (800) 351-2465 to find out if a particular drug is on the Blue Shield drug formulary, or to request a copy of the formulary. For the most current information, you can access the formulary on the Blue Shield Web site at [mylifepath.com](http://mylifepath.com).
- 7 If a member requests a brand-name drug or the physician indicates Dispense As Written (DAW) for a prescription, when an equivalent generic drug is available, and the brand-name drug deductible has been satisfied, the member pays the generic copayment plus the cost difference between the brand and generic drug.
- 8 Home self-administered injectables are available through pharmacies designated in a specialty network. They are only covered when obtained from a pharmacy designated in a specialty network, and they require prior authorization from Blue Shield Pharmacy Services.
- 9 All covered orthotic equipment and services have a benefit maximum of \$2,000 per member per calendar year, except those services covered under the Diabetes Care benefit.
- 10 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 (COI)*.
- 11 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.
- 12 Members have coverage for inpatient benefits of no less than 48 hours following a normal delivery and no less than 96 hours following a delivery by cesarean section, unless the treating physician, in consultation with the mother, decides on an early discharge.
- 13 Member is responsible for the office visit copayment in addition to the \$25 copayment.