

Shield Spectrum PPOSM Plan, Zero Deductible

Benefit Summary

(Uniform Health Plan Benefits and Coverage Matrix)

Effective January 1, 2007

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.

DEDUCTIBLES [#]	Preferred Providers ¹	Non-Preferred Providers ¹
Calendar-Year Medical Deductibles		
• Per individual/per family	None	\$500/\$1,000
Calendar-year Copayment Maximum[#]		
• Per individual/per family	\$2,000/\$4,000	\$5,000/\$10,000
LIFETIME MAXIMUMS		
	\$6,000,000	
Covered Services	Member Copayment	
PROFESSIONAL SERVICES		
Physician services		
• Physician and specialist office visits	\$10/visit (Deductible waived)	30% [#]
• Laboratory and X-rays	\$10/visit	30%
• Allergy testing or treatment	10%	30%
• Diagnostic testing	10%	30%
Preventive care		
• 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
Well-baby care		
• Office visits and consultations Includes: eye/ear screenings, immunizations, vaccinations	\$10/visit (Deductible waived)	Not covered
• Laboratory	\$10/visit	Not covered
OUTPATIENT SERVICES		
• Outpatient surgery in hospital/facility	10%	30% ²
• Outpatient treatment and necessary supplies	10%	30% ^{2#}
HOSPITALIZATION SERVICES		
• Inpatient physician services (including pregnancy and maternity care)	10%	30%
• Semi-private room and board, medically necessary services and supplies	10%	30% ²
Bariatric surgery (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity) ³		
• Inpatient services	10%	30% ²
Skilled nursing facility (SNF) services⁴ (Combined maximum of up to 100 preauthorized days per calendar-year; semi-private accommodations)		
• Freestanding SNF	10%	10%
• Hospital SNF unit	10%	30% ²
EMERGENCY HEALTH COVERAGE		
• Facility services (Not resulting in a direct admission; deductible waived)	\$50 [#] + 10%	\$50 [#] + 30%
• Facility services (Resulting in a direct admission)	10%	10%
• Emergency room physician services	10%	10%
AMBULANCE SERVICES	10%	10%

An Independent Member of the Blue Shield Association A11969-0-d (1/07)

Covered Services

Member Copayment

PRESCRIPTION DRUG COVERAGE^{#5} (DEDUCTIBLE WAIVED)

(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.

Participating Pharmacy

Non-Participating Pharmacy

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

	Participating Pharmacy	Non-Participating Pharmacy
• Calendar-Year Brand-Name Drug Deductible		None
• 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	30%/prescription	Not covered
(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	\$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

DURABLE MEDICAL EQUIPMENT

Preferred Providers¹

Non-Preferred Providers¹

• 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)	10%	30%
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MENTAL HEALTH SERVICES (PSYCHIATRIC)⁶

MHSA Participating Providers¹

MHSA Non-Participating Providers¹

• Inpatient hospital facility services	10%	30% ²
• Outpatient visits for severe mental health conditions	\$10/visit (Deductible waived)	30% [#]
• Outpatient visits for non-severe mental health conditions (Up to 20 visits per calendar-year combined with outpatient chemical dependency visits) ⁷	\$25/visit [#]	Not covered

CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)⁶, PLEASE SEE FOOTNOTE 9

• Inpatient services for medical acute detoxification	10%	30% ²
• Outpatient visits (Up to 20 visits per calendar-year combined with outpatient non-severe mental health visits) ⁷	\$25/visit [#]	Not covered

HOME HEALTH SERVICES

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

Preferred Providers¹

Non-Preferred Providers¹

• Home health and home infusion care (For home self-administered injectables see "Prescription Drug Coverage.")	10%	10% with prior authorization
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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	10%	10% with prior authorization

Alternative care⁷

• Chiropractic services (Up to 12 visits per calendar-year)	\$25/visit	30%
• Acupuncture services (Up to 20 visits per calendar-year)	\$25/visit	\$25/visit

Rehabilitative therapy services

• Outpatient visits	\$25/visit	30%
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Pregnancy and maternity care

• Prenatal and postnatal professional (physician) services (For all necessary inpatient hospital services, see "Hospitalization Services.")	10%	30%
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Family planning

• Family planning counseling	\$10/visit (Deductible waived)	Not covered
• Elective abortion ⁸ , tubal ligation ⁸ , vasectomy ⁸	10%	Not covered

Covered out-of-state benefits Benefits provided through BlueCard [®] Program, for out-of-state	10% or \$10 copay	30%
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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.

Covered Services

Member Copayment

Diabetes care

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|---|--|------------|-----|
| • | Equipment, devices and non-testing supplies
(For testing supplies, see "Prescription Drug Coverage.") | 10% | 30% |
| • | Self-management training and education (If billed by your provider, you will also be responsible for the office visit copayment) | \$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.
- 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'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.
- 2 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.
- 3 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 of bariatric services from non-preferred providers. In addition, if prior authorized by Blue Shield of California, 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 *Evidence of Coverage* for further benefit details.
- 4 Services may require prior authorization by Blue Shield. When these services are prior authorized, members pay the preferred or participating provider level.
- 5 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. 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). Since this plan's prescription drug coverage is creditable, you do not have to enroll in Medicare Part D while you maintain this coverage; however, you should be aware that if you have a subsequent break in this coverage of 63 days or more before enrolling in Medicare Part D you could be subject to payment of higher Medicare Part D premiums.
- 6 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.
- 7 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.
- 8 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.
- 9 **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.