Blue Shield of California
An Independent Member of the Blue Shield Association

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. **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 the Blue Shield of California Life & Health Insurance Company.		
DEDUCTIBLE*	$5,000 ($10,000 Family)	
COPAYMENTS	$35 with Preferred Providers Not applicable with Non-Preferred Providers	
COINSURANCE	30% with Preferred **Choice** Hospitals 40% with Preferred **Affiliate** Hospitals 50% with Non-Preferred Providers	
CALENDAR-YEAR COPAYMENT MAXIMUM (Includes the plan deductible. Some services do not apply.)	Services with Preferred **Choice** Providers** Services with All Providers:	$7,000 ($14,000 family) $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 maximum also includes copayments or coinsurance paid from preferred providers when there is no designation of "**Choice** Hospital" and "**Affiliate** Hospital."

COVERED SERVICES (subject to the plan deductible, unless noted)	**MEMBER COPAYMENTS** **With Preferred Providers,[1] you pay**		**With Non-Preferred Providers,[1] you pay**
PROFESSIONAL SERVICES			
– Office visits, consultations, OB/GYN and specialist visits, second surgical opinions, urgent care services	$35 copayment		50%
– Allergy testing and treatment	30%		50%
PREVENTIVE CARE			
– 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 copayment		Not covered
OUTPATIENT SERVICES			
– Non-Emergency surgery in outpatient department of hospital	30% w/Choice Hospitals	40% w/Affiliate Hospitals	50%[2,3]
– Outpatient or Out-of-Hospital X-ray and Laboratory	30%		50%
– Non-Emergency surgery in an Ambulatory Surgery Center (ASC)	30%		50%[2,3]
– 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 (subject to the plan deductible, unless noted)	MEMBER COPAYMENTS With Preferred Providers,[1] you pay		With Non-Preferred Providers,[1] you pay
HOSPITALIZATION SERVICES			
– Inpatient physician visits and consultations, surgeons and assistants, anesthesiologists, pathologists, radiologists	30%		50%
– Inpatient semiprivate room and board, services and supplies and subacute care	30% w/Choice Hospitals	40% w/Affiliate Hospitals	50%[2,3]
EMERGENCY HEALTH COVERAGE			
– Outpatient Emergency room facility services[4]	30%		30%
– Inpatient physician visits, semiprivate room and board, services and supplies and subacute care not resulting in admission	30%		30%
AMBULANCE SERVICES (Surface or Air)[5]	30%		30%
PRESCRIPTION DRUG COVERAGE[6] (outpatient; brand-name drugs are subject to a $500 brand-name drug deductible per person, per calendar year; includes oral contraceptives and diaphragms and diabetic testing supplies)	**At Participating Pharmacies** (Up to a 30-day supply)		**Mail Service Prescriptions** (Up to a 60-day supply)
– Generic formulary drugs	$10/prescription[2]		$20/prescription[2]
– Formulary brand-name drugs[‡,7]	$30+10%/prescription (maximum copayment of $60 per prescription)[2]		$60+10% prescription (maximum copayment of $150 per prescription)[2]
– Non-formulary brand-name drugs[‡,7]	$45 or 50% (whichever is greater)[2]		$75 or 50% (whichever is greater)[2]
– Home Self-Administered Injectables[8]	30%[2]		Not Covered
DURABLE MEDICAL EQUIPMENT			
– Prosthetic Appliances, Home Medical Equipment and Orthotic Equipment[9]	30%		50%
– Diabetes Care Supplies	30%		50%
	With MHSA Participating Providers,[1] you pay		**With MHSA Non-Participating Providers,[1] you pay**
MENTAL HEALTH SERVICES[10,11]			
– Inpatient Hospital Facility Services	30%		50%[2,3]
– Inpatient Physician Services	30%		50%[3]
– Outpatient visits for severe mental health conditions	$35 copayment		50%[3]
– 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)[11]			
– Inpatient Hospital Facility Services for medical acute detoxification	30% w/ Choice Hospitals	40% w/Affiliate Hospitals	50%[2,3]
– 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
COVERED SERVICES (subject to the plan deductible, unless noted)	**MEMBER COPAYMENTS** With Preferred Providers,[1] you pay		With Non-Preferred Providers,[1] you pay
HOME HEALTH SERVICES (up to 90 preauthorized visits per calendar year)	30%		30% (after Blue Shield prior authorizes)

COVERED SERVICES (subject to the plan deductible, unless noted)	MEMBER COPAYMENTS With Preferred Providers,[1] you pay		With Non-Preferred Providers,[1] you pay
OTHER			
Pregnancy and Maternity Care[12]			
– Outpatient prenatal and postnatal care	30%		50%
– Delivery and all necessary inpatient hospital services	30% w/Choice Hospitals	40% w/Affiliate Hospitals	50%[2,3]
Family Planning			
– Consultations, tubal ligation, vasectomy, elective abortion	30%		Not Covered
– Injectable Contraceptives[13]	$25 copayment[2]		Not Covered
Rehabilitation Services			
– Physical, occupational or respiratory therapy received in a provider's office or outpatient department of a hospital (12 visit combined max/calendar year for rehabilitation and speech therapy services)	30%		50%
Speech Therapy (12 visit combined max/calendar year for rehabilitation and speech therapy services)			
– 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%[2] 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 copayment		50%
Dental Services and Life Insurance (Optional dental benefits and life insurance are available. See pages 31-33 for details.)			

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 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 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 percentage of the allowable amount plus any charges that exceed Blue Shield's allowable amount. Charges above the allowable amount do not count toward the plan deductible or copayment 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 and copayment, 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 do not count toward the copayment 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%, 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. 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 **www.mylifepath.com.**

7 If a member requests a brand-name drug or the physician states Dispense As Written (DAW), 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. Member pays a copayment of 10% for formulary brand-name drugs. The 10% members' responsibility is calculated by taking Blue Shield's contracted rate, minus the dollar copayment, and then taking 10% of the remaining amount.

8 Home self-administered injectables are available through a network of participating pharmacies. They are only covered when obtained from a participating pharmacy, 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 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.