



Shield Spectrum PPO Savings Plan

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 EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

PPO Savings Plan benefits provided before you need to meet the deductible are shown 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 SAVINGS PLAN	PPO SAVINGS PLAN 2400 (INDIVIDUAL)/4800 (FAMILY)
DEDUCTIBLE*	\$2,400 Individual/\$4,800 Family
CALENDAR-YEAR OUT-OF-POCKET MAXIMUM (Includes the plan deductible.) Please Note: The deductibles and out-of-pocket maximum amounts may increase annually to reflect federal cost-of-living adjustment.	\$3,200 Individual/\$5,800 Family
LIFETIME MAXIMUM	\$6,000,000
* 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.	

COVERED SERVICES (once the plan deductible has been met, unless noted)	MEMBER COPAYMENTS	
	With Preferred Providers, ¹ you pay	With Non-Preferred Providers, ¹ you pay
PROFESSIONAL SERVICES		
Physician services		
– Office visits, consultations, OB/GYN and specialist visits, second surgical opinions, allergy testing and treatment, urgent care services	30%	50%
Laboratory, X-rays and diagnostics	30%	50%
PREVENTIVE CARE (not subject to the plan deductible, unless noted)		
– Annual Routine Physical Exam, Gynecological Exam, Well-baby care office visits	\$35	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%	Not Covered
OUTPATIENT SERVICES		
– Outpatient hospital services and supplies	30% w/Choice Hospitals	40% w/ Affiliate Hospitals
HOSPITALIZATION SERVICES		
Inpatient Services – non-emergency		
– Inpatient physician visits and consultations, surgeons and assistants, anesthesiologists, pathologists, radiologists	30%	50%
– Inpatient semiprivate room and board, services and supplies and subacute care services, received in a hospital or Ambulatory Surgery Center (ASC)	30% w/Choice Hospitals	40% w/Affiliate Hospitals
EMERGENCY HEALTH COVERAGE		
– Emergency room services ³ (\$75 copayment waived if the member is admitted directly to the hospital as an inpatient)	\$75, then 30%	\$75, then 30%
– Inpatient physician and hospital services and supplies	30%	30%

COVERED SERVICES (once the plan deductible has been met, unless noted)	MEMBER COPAYMENTS	
	With Preferred Providers, ¹ you pay	With Non-Preferred Providers, ¹ you pay
AMBULANCE SERVICES (Surface or air) ⁴	30%	30%
PRESCRIPTION DRUG COVERAGE ⁵ (outpatient; subject to the plan deductible, oral contraceptives and diaphragms covered)	Coverage can be obtained at any retail pharmacy. Member pays full price and submits claims to Blue Shield of California. After medical deductible is met, 30% copayment applies. Prescriptions are available at reduced prices through the Prescription Value Program, a mail service pharmacy option.	
DURABLE MEDICAL EQUIPMENT – Prosthetic Appliances, Home Medical Equipment and Orthotic Equipment ⁶	30%	50%
	With MHA Participating Providers, ⁸ you pay	With MHA Non-Participating Providers, ⁸ you pay
MENTAL HEALTH SERVICES ^{7,8} – Inpatient Hospital Facility Services – Inpatient Physician 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 chemical dependency visits)	30% 30% 30%	50% (to \$300 per day) ² 50% Not Covered
CHEMICAL DEPENDENCY SERVICES (Substance Abuse) ⁸ – Inpatient Hospital Facility Services for medical acute detoxification – Inpatient Physician Services for medical acute detoxification – Outpatient visits (up to 20 visits per calendar year combined with non-severe mental health visits)	30% w/Choice Hospitals 30% 30%	40% w/Affiliate Hospitals 50% Not Covered
	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%
OTHER Pregnancy and Maternity Care ⁹ – Outpatient prenatal and postnatal care – Delivery and all necessary inpatient hospital services	30% 30% w/Choice Hospitals	50% 50% (to \$300 per day) ²
	40% w/Affiliate Hospitals	
Family Planning – Consultations, tubal ligation, vasectomy, elective abortion – Injectable Contraceptives ¹⁰	30% 30%	Not Covered Not Covered
Rehabilitation Services – Received in the office of a physician, physical therapist or occupational therapist or hospital outpatient department	30%	50%
Chiropractic Services (up to 12 visits per calendar year) – Received from a chiropractor ¹¹	50% up to \$25 (member responsible for all charges over \$25)	Not Covered
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% in hospital or freestanding SNF

COVERED SERVICES (once the plan deductible has been met, unless noted)	MEMBER COPAYMENTS	
	With Preferred Providers, ¹ you pay	With Non-Preferred Providers, ¹ you pay
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 care supplies	30%	50%
– Diabetes Self-Management Training	30%	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.

- 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. Mental health and substance abuse 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 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 Members pay the preferred provider level, 30%, for physician services received during an emergency room visit.
- 4 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.
- 5 Includes coverage for medically necessary drugs, including drugs to treat diabetes.
- 6 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.
- 7 For a listing of Severe Mental Illnesses including Serious Emotional Disturbances of a Child, and other benefit details, please refer to the EOC.
- 8 Blue Shield of California has contracted with a specialized health care service plan to act as our Mental Health Services Administrator (MHSA). The MHSA provides mental health and substance abuse 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 providers.
- 9 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 earlier discharge.
- 10 Member is responsible for the office visit copayment in addition to the 30% copayment.
- 11 Blue Shield will pay up to \$25 of the allowed charges. Member is responsible for all charges over \$25.

