

# Shield Spectrum PPO Plus Plan 250 Premier

**THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE, DISCLOSURE FORM AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.**

## Benefit Summary (For groups of 51 and above) (Uniform Health Plan Benefits and Coverage Matrix)

Highlights: A description of the prescription drug coverage is provided separately.

There are Choice and Affiliate providers. Different copayments or copayment percentages may apply for Choice or Affiliate providers. Refer to the footnotes for further information.

DEDUCTIBLES <sup>#</sup> (All providers combined)	Preferred Providers <sup>1</sup>	Non-Preferred Providers <sup>1</sup>
<b>Calendar-year medical deductible</b>	\$250 per individual/\$500 per family	
<b>Calendar-year copayment maximum<sup>#</sup></b>		
• Per individual/per family	\$1,000/\$2,000	\$3,000/\$6,000
<b>LIFETIME MAXIMUMS</b>	\$6,000,000	

Covered Services	Member Copayment	
<b>PROFESSIONAL SERVICES</b>		
<b>Physician services</b>		
• Physician and specialist office visits	\$10/visit*	30% <sup>#</sup>
• Laboratory and X-rays	\$10/visit	30%
• Allergy testing or treatment	10%	30%
• Diagnostic testing	10%	30%
<b>Preventive care</b>		
• Annual physical exam, eye/ear screenings and immunizations according to age schedule	\$10/visit*	Not covered
• Laboratory, including mammogram and Pap test screening or other FDA-approved cervical cancer screening tests	\$10/visit*	Not covered
<b>Well-baby care</b>		
• Office visits and consultations Includes: eye/ear screenings, immunizations, vaccinations	\$10/visit*	Not covered
• Laboratory	\$10/visit	Not covered
<b>OUTPATIENT SERVICES</b>		
• Outpatient surgery in hospital/facility	10% <sup>2</sup>	30% <sup>3#</sup>
• Outpatient treatment, renal dialysis and necessary supplies	10% <sup>2</sup>	30% <sup>3#</sup>
<b>HOSPITALIZATION SERVICES</b>		
• Inpatient physician services (including pregnancy and maternity care)	10%	30% <sup>#</sup>
• Semi-private room and board, medically necessary services and supplies	10% <sup>2</sup>	30% <sup>3#</sup>
<b>Skilled nursing facility (SNF) services<sup>4</sup></b> (Up to 100 combined days per calendar year; semi-private accommodations)		
• Freestanding SNF	10%	10% with prior authorization
• Hospital SNF unit	10%	30% <sup>3#</sup>
<b>EMERGENCY HEALTH COVERAGE</b>		
• Facility services (The \$100 copayment per emergency room visit is waived if the member is directly admitted to the hospital for inpatient services)		\$100* <sup>#</sup>
• Emergency room physician services	10%	10%
<b>AMBULANCE SERVICES</b>	10%	10%
<b>PRESCRIPTION DRUG COVERAGE</b>		
	A description of your outpatient prescription drug coverage is provided separately. If you do not have the separate drug sheet that goes with this matrix, please contact your benefits administrator or call Customer Services at 800-200-3242.	
<b>DURABLE MEDICAL EQUIPMENT</b>		
• Home medical equipment, prosthetics/orthotics <sup>5</sup>	10%	30%

Covered Services	Member Copayment	
	MHSA Participating Providers <sup>1</sup>	MHSA Non-Participating Providers <sup>1</sup>
<b>MENTAL HEALTH SERVICES (PSYCHIATRIC)<sup>6</sup></b>		
• Inpatient hospital facility services	10%	30% <sup>3#</sup>
• Outpatient visits for severe mental health conditions	\$10/visit*	30% <sup>#</sup>
• Outpatient visits for non-severe mental health conditions (Up to 20 visits per calendar year combined with outpatient chemical dependency visits) <sup>7</sup>	\$25/visit <sup>#</sup>	Not covered
<b>CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)<sup>6</sup> Please see footnote 8</b>		
• Inpatient services for medical acute detoxification	See "Hospitalization Services" <sup>#</sup>	See "Hospitalization Services" <sup>#</sup>
• Outpatient visits (Up to 20 visits per calendar year combined with outpatient non-severe mental health visits) <sup>7</sup>	\$25/visit <sup>#</sup>	Not covered
<b>HOME HEALTH SERVICES<sup>4</sup></b> (Combined maximum of 100 prior authorized visits per calendar year)		
• Home health and home infusion care (See "Prescription Drug Coverage" for home self-administered injectables)	<b>Preferred Providers<sup>1</sup></b> 10%	<b>Non-Preferred Providers<sup>1</sup></b> 10% with prior authorization
<b>OTHER</b>		
<b>Hospice<sup>4</sup></b>		
• 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
<b>Alternative care<sup>7</sup></b>		
• 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
<b>Rehabilitative therapy services</b>		
• Outpatient visits	\$10/visit	30%
<b>Pregnancy and maternity care</b>		
• Prenatal and postnatal physician office visits (For all necessary inpatient hospital services, see "Hospitalization Services.")	10%	30% <sup>#</sup>
<b>Family planning</b>		
• Family planning counseling	\$10/visit*	Not covered
• Elective abortion, tubal ligation, vasectomy	10% <sup>2</sup>	Not covered
<b>Covered out-of-state benefits</b> Benefits provided through BlueCard Program, for out-of-state 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.	10% or \$10 copay	30%
<b>Diabetes care</b>		
• Equipment, devices and non-testing supplies (for testing supplies, see "Prescription Drug Coverage")	10%	30%
• Self-management training and education	\$10/visit	30%
<b>Optional Benefits</b>	Optional dental, vision, or infertility benefits are available. If your employer purchased any of these benefits, a description of the benefit is provided separately.	

\* Benefits are not subject to the calendar-year medical deductible.

# Copayments and charges for services not included in the calculation of 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*, the *Disclosure Form* and the Group Health Service Contract 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 There are Choice and Affiliate PPO providers. An additional 10 percent member copayment will be charged when non-emergency hospital facility services are obtained from an Affiliate provider.

3 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.

4 Services may require prior authorization by Blue Shield. When these services are prior authorized, members pay the preferred or participating provider amount.

5 Orthosis benefits, except for services covered under diabetes care, are limited to a \$2,000 maximum per person per calendar year.

6 Mental health and chemical dependency services, other than medical acute detoxification, are accessed through the mental health services administrator (MHSA) - US Behavioral Health Plan, California (USBHPC) - using MHSA participating and non-participating providers. 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 **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 for subsequently enacted state or federal legislation.



# Access+ HMO<sup>SM</sup> Plus Plan 10 Premier

Benefit Summary (For groups of 51 and above)  
(Uniform Health Plan Benefits and Coverage Matrix)

**THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE, DISCLOSURE FORM AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.**

Highlights: A description of the prescription drug coverage is provided separately.

There are Choice and Affiliate providers. Different copayments may apply for Choice or Affiliate providers. Refer to the footnotes for further information.

## DEDUCTIBLES

<b>Calendar-year medical deductible</b>	None
<b>Calendar-year copayment maximum<sup>#</sup></b> (For many covered services)	\$1,000 per individual / \$2,000 per family

## LIFETIME MAXIMUMS

None

Covered Services	Member Copayment
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### PROFESSIONAL SERVICES

#### Physician services – outpatient

– Physician and authorized specialist office visits	\$10/visit
<small>Note: A woman may self-refer to an OB/GYN or family practice physician in her personal physician's medical group or IPA for OB/GYN services.</small>	
– Allergy testing or treatment	\$10/visit
<b>Access+ Specialist<sup>SM</sup></b> (Self-referred office visits and consultations only) <sup>1</sup>	\$30/visit

#### Laboratory, X-ray and diagnostic tests

No charge

#### Preventive care

– Annual routine physical exam, eye/ear screenings and immunizations according to age schedule	No charge
<small>Note: A woman may self-refer to an OB/GYN or family practice physician in her personal physician's medical group or IPA for OB/GYN services.</small>	

### OUTPATIENT SERVICES

#### Non-emergency

– Outpatient surgery in hospital/facility <sup>2</sup>	No charge
– Outpatient treatment (except as described under "Rehabilitative therapy services"), renal dialysis and necessary supplies <sup>3</sup>	No charge

### HOSPITALIZATION SERVICES

– Inpatient physician services, including pregnancy and maternity care	No charge
– Semi-private room and board, medically necessary services and supplies <sup>2</sup>	No charge
– Skilled nursing facility (SNF) services <sup>4</sup>	No charge

**EMERGENCY HEALTH COVERAGE** (Waived if the member is directly admitted to the hospital for inpatient services) \$100/visit

### AMBULANCE SERVICES

\$50

### PRESCRIPTION DRUG COVERAGE

A description of your outpatient prescription drug coverage is provided separately. If you do not have the separate drug sheet that goes with this matrix, please contact your benefits administrator or call Member Services at 800-424-6521.

### DURABLE MEDICAL EQUIPMENT

– Home medical equipment, prosthetics/orthotics <sup>5</sup> , oxygen, colostomy/ostomy supplies	20% of allowed charges
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### MENTAL HEALTH SERVICES (PSYCHIATRIC)<sup>6</sup>

– Inpatient hospital facility services	No charge
– Outpatient visits for severe mental health conditions	\$10/visit
– Outpatient visits for non-severe mental health conditions <small>(Up to 20 visits per calendar year combined with outpatient chemical dependency visits)</small>	\$25/visit

### CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)<sup>6</sup> Please see footnote 9

– Inpatient services for medical acute detoxification	See "Hospitalization Services"
– Outpatient visits (Up to 20 visits per calendar year combined with outpatient non-severe mental health visits)	\$25/visit

Covered Services	Member Copayment
<b>HOME HEALTH SERVICES</b>	
- Agency visits (Up to 100 visits per calendar year)	\$10/visit
- Medical supplies/IV solutions (For home self-administered injectable medications, see "Prescription Drug Coverage")	No charge
<b>OTHER</b>	
<b>Hospice</b>	
- Routine home care and inpatient respite care	No charge
- 24 hour continuous home care and general inpatient care	No charge
<b>Pregnancy and maternity care</b>	
- Prenatal and postnatal physician office visits (For all necessary inpatient hospital services, see "Hospitalization Services.")	No charge
<b>Family planning and infertility services</b>	
- Family planning counseling	\$10/visit
- Diagnosis and treatment of causes of infertility (Excludes in vitro fertilization, injectables for infertility, artificial insemination and GIFT)	50% of allowed charges
- Tubal ligation <sup>7,8</sup> and elective abortion <sup>8</sup>	\$100
- Vasectomy <sup>8</sup>	\$75
<b>Rehabilitative therapy services</b>	
- Outpatient visits (Copayment applies to all place of services, including professional and facility settings)	\$10/visit
<b>Urgent care outside service area (BlueCard Program)</b>	
	\$50/visit
<b>Diabetes care</b>	
- Equipment, devices and non-testing supplies (For testing supplies, see "Prescription Drug Coverage.")	20% of allowed charges
- Self-management training and education	\$10/visit
<b>Optional benefits</b>	Optional dental, vision, chiropractic, chiropractic and acupuncture, or infertility benefits are available. If your employer purchased any of these benefits, a description of the benefit is provided separately.

# Copayments and charges for services not included in the calculation of the member's calendar-year copayment maximum continue to be the member's responsibility after the calendar-year copayment maximum is reached. Please refer to the *Evidence of Coverage*, the *Disclosure Form* and the Group Health Service Contract for exact terms and conditions of coverage.

- To use this option, members must select a personal physician who is affiliated with a medical group or IPA that is an Access+ provider group, which offers the Access+ *Specialist* feature. Members should then select a specialist within that medical group or IPA. Access+ *Specialist* visits for mental health or substance abuse services must be provided by a MHSA network participating provider. Access+ *Specialist* visits for mental health services for non-severe mental illness, or non-serious emotional disturbances of a child, or substance abuse will accrue toward the 20 visit per calendar-year maximum.
- There are Choice and Affiliate Access+ HMO hospitals. An additional \$100 member copayment per admission, visit or surgery will be charged for non-emergency hospital services obtained from an Affiliate provider.
- There are Choice and Affiliate Access+ HMO hospitals. An additional \$10 member copayment per visit will apply for all non-emergency outpatient treatment obtained from an Affiliate provider.
- Skilled nursing services are limited to 100 days during a calendar year except when received through a hospice program provided by a participating hospice agency. This 100-day maximum on skilled nursing services is a combined maximum between SNF in a hospital unit and skilled nursing facilities.
- Orthosis benefits, except for services covered under diabetes care, are limited to a \$2,000 maximum per person per calendar year.
- Mental health and chemical dependency services, other than medical acute detoxification, are accessed through the mental health services administrator (MHSA) - US Behavioral Health Plan, California (USBHPC) - using MHSA participating providers. Services for medical acute detoxification are accessed through Blue Shield using Blue Shield HMO 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.
- Copayment waived when procedure is performed in conjunction with delivery or abdominal surgery.
- Physician services copayment in the office or outpatient hospital facility only. If procedure is performed in a hospital facility setting, additional hospital services copayment may apply.
- 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 for subsequently enacted state or federal legislation.