



# 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.) <b>Please Note:</b> 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 (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	30%	50%	
– Allergy testing and treatment	30%	50%	
<b>PREVENTIVE CARE</b>			
– 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	
<b>OUTPATIENT SERVICES</b>			
– Non-emergency services and procedures, Outpatient surgery in a hospital	30% w/ Choice Hospitals	40% w/ Affiliate Hospitals	50% <sup>2</sup>
– Outpatient X-ray and laboratory	30%		50%
– Non-emergency surgery in an Ambulatory Surgery Center (ASC)	30%		50% <sup>2</sup>
<b>HOSPITALIZATION SERVICES</b>			
– 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% <sup>2</sup>
<b>EMERGENCY HEALTH COVERAGE</b>			
– Emergency room services <sup>3</sup> (\$75 copayment waived if the member is admitted directly to the hospital as an inpatient)	\$75 + 30%		\$75 + 30%
– ER Physician visits <sup>3</sup>	30%		30%

COVERED SERVICES (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>AMBULANCE SERVICES</b> (Surface or air) <sup>4</sup>	<b>At Participating Pharmacies</b> (Up to a 30-day supply)	<b>Mail Service Prescriptions</b> (Up to a 60-day supply)
<b>PRESCRIPTION DRUG COVERAGE<sup>5</sup></b> (outpatient; subject to the plan deductible, oral contraceptives, diaphragms, asthma inhalers and inhaler spacers covered)	30%	50%
<b>DURABLE MEDICAL EQUIPMENT</b>		
– Prosthetic Appliances, Home Medical Equipment, Asthma Nebulizers (including face masks and tubing), Peak Flow Monitors and Orthotic Equipment <sup>6</sup>	30%	50%
	With MESA Participating Providers, <sup>1</sup> you pay	With MESA Non-Participating Providers, <sup>1</sup> you pay
<b>MENTAL HEALTH SERVICES<sup>7,8</sup></b>		
– Inpatient Hospital Facility Services	30%	50% <sup>2</sup>
– Inpatient Physician Services, Outpatient visits for severe mental health conditions	30%	50%
– Outpatient visits for non-severe mental health conditions (up to 20 visits per calendar year combined with chemical dependency visits)	30%	Not Covered
<b>CHEMICAL DEPENDENCY SERVICES</b> (Substance Abuse) <sup>8</sup>		
– Inpatient Hospital Facility Services for medical acute detoxification	30% w/Choice Hospitals	40% w/Affiliate Hospitals
– 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
<b>HOME HEALTH SERVICES</b> (up to 90 preauthorized visits per calendar year)	30%	Not Covered
<b>OTHER</b>		
<b>Pregnancy and Maternity Care<sup>9</sup></b>		
– Outpatient prenatal and postnatal care	30%	50%
– Delivery and all necessary inpatient hospital services	30% w/Choice Hospitals	40% w/Affiliate Hospitals
<b>Family Planning</b>		
– Consultations, tubal ligation, vasectomy, elective abortion	30%	Not Covered
– Injectable Contraceptives <sup>10</sup>	30%	Not Covered
<b>Rehabilitation Services</b>		
– Physical, occupational, or respiratory therapy received in a provider's office or outpatient department of a hospital	30%	50%
<b>Chiropractic Services</b> (up to 12 visits per calendar year)		
– Received from a chiropractor <sup>11</sup>	50% up to \$25 (member responsible for all charges over \$25)	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**

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

30% in hospital or freestanding SNF

50% in hospital or freestanding SNF

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

**Out-of-State Services**

30% with BlueCard Participating Providers

50% with all other providers

(full plan benefits covered nationwide with the BlueCard program)

**Diabetes Care**

– Diabetes Self-Management Training

30%

50%

– Diabetic Care Supplies

30%

50%

**Dental Services and Life Insurance** (Optional dental benefits and life insurance are available. See pages 36-38 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 percent, 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 Prosthetic Appliances, Home Medical Equipment and 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 *Evidence of Coverage* (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 percent copayment.
- 11 Blue Shield will pay up to \$25 of the allowed charges. Member is responsible for all charges over \$25.