Shield Spectrum PPO℠ 1800-80/50

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

Blue Shield of California

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

Effective July 1, 2012

	Preferred Providers[1]	Non-Preferred Providers[1]
Calendar Year Medical Deductible[2] (All providers combined)	$1,800 per individual / $3,600 per family	
Calendar Year Copayment Maximum[2] (Copayments for Preferred Providers accrue to both Preferred and Non-Preferred Provider Calendar-year Copayment Maximum amounts.)	$5,400 per individual / $10,800 per family	$10,800 per individual / $21,600 per family
LIFETIME BENEFIT MAXIMUM	None	

Covered Services	**Member Copayment**	
PROFESSIONAL SERVICES	**Preferred Providers[1]**	**Non-Preferred Providers[1]**
Professional (Physician) Benefits		
• Physician and specialist office visits	20% (Not subject to the Calendar-Year Deductible)	50%
• CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine[3] (prior authorization is required)	20%	50%
• Other outpatient X-ray, pathology and laboratory (Diagnostic testing by providers other than outpatient laboratory, pathology, and imaging departments of hospitals/facilities)[3]	20%	50%
Allergy Testing and Treatment Benefits		
• Office visits (includes visits for allergy serum injections)	20%	50%
Preventive Health Benefits		
• Preventive Health Services (As required by applicable federal and California law.)	No Charge (Not subject to the Calendar-Year Deductible)	Not Covered
OUTPATIENT SERVICES		
Hospital Benefits (Facility Services) The maximum allowed charges for non-emergency surgery and services performed in a non-participating Ambulatory Surgery Center or outpatient unit of a non-preferred hospital is $350 per day. Members are responsible for 50% of this $350 per day, plus all charges in excess of $350.		
• Outpatient surgery performed at an Ambulatory Surgery Center[4]	20%	50%
• Outpatient surgery in a hospital	$125 per surgery + 20%	50%
• Outpatient Services for treatment of illness or injury and necessary supplies (Except as described under "Rehabilitation Benefits")	20%	50%
• CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine performed in a hospital (prior authorization is required)[3]	$100 per visit + 20%	50%
• Other outpatient X-ray, pathology and laboratory performed in a hospital[3]	$25 per visit + 20%	50%
• Bariatric Surgery (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only)[5]	$125 per surgery + 20%	50%
HOSPITALIZATION SERVICES		
Hospital Benefits (Facility Services)		
• Inpatient Physician Services	20%	50%
• Inpatient Non-emergency Facility Services (Semi-private room and board, and medically-necessary Services and supplies, including Subacute Care)	$250 per admission + 20%	50%[6]
• Bariatric Surgery (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only)[5]	$250 per admission + 20%	50%[6]
Skilled Nursing Facility Benefits[7] (Combined maximum of up to 100 prior authorized days per Calendar Year; semi-private accommodations)		
• Services by a free-standing Skilled Nursing Facility	20%	20%[7]
• Skilled Nursing Unit of a Hospital	20%	50%[6]

EMERGENCY HEALTH COVERAGE		
• Emergency room Services not resulting in admission (Copayment does not apply if the member is directly admitted to the hospital for inpatient services) (If ER services do not result in a direct admission the Calendar-Year Deductible does not apply)	$100 per visit + 20%	$100 per visit + 20%
• Emergency room Services resulting in admission (when the member is admitted directly from the ER)	$250 per admission + 20%	$250 per admission + 20%
• Emergency room Physician Services	20%	20%
AMBULANCE SERVICES		
• Emergency or authorized transport	20%	20%
PRESCRIPTION DRUG COVERAGE		
Outpatient Prescription Drug Benefits	A description of your outpatient prescription drug coverage is provided separately. If you do not have the separate drug summary that goes with this benefit summary, please contact your benefits administrator or call Customer Service at 800-200-3242.	
PROSTHETICS/ORTHOTICS		
• Prosthetic equipment and devices (Separate office visit copay may apply)	20%	50%
• Orthotic equipment and devices (Separate office visit copay may apply)	20%	50%
DURABLE MEDICAL EQUIPMENT		
• Durable Medical Equipment	20%	50%
MENTAL HEALTH SERVICES (PSYCHIATRIC)[8]	**MHSA Participating Providers[1]**	**MHSA Non-Participating Providers[1]**
• Inpatient Hospital Services	$250 per admission + 20%	50%[6]
• Outpatient Mental Health Services	20% (Not subject to the Calendar-Year Deductible)	50%
CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)[9]		
Please see footnote 14		
• Chemical dependency and substance abuse services	Not Covered	Not Covered
HOME HEALTH SERVICES[10]	**Preferred Providers[1]**	**Non-Preferred Providers[1]**
• Home health care agency Services (up to 100 prior authorized visits per Calendar Year)	20%	Not Covered[10]
• Home infusion/home intravenous injectable therapy and infusion nursing visits provided by a Home Infusion Agency	20%	Not Covered[10]
OTHER		
Hospice Program Benefits[10]		
• Routine home care	No Charge	Not Covered[10]
• Inpatient Respite Care	No Charge	Not Covered[10]
• 24-hour Continuous Home Care	20%	Not Covered[10]
• General Inpatient care	20%	Not Covered[10]
Chiropractic Benefits[11]		
• Chiropractic Services - (provided by a chiropractor) (up to 12 visits per Calendar Year)	$25 per visit	50%
Acupuncture Benefits		
• Acupuncture	Not Covered	Not Covered
Rehabilitation Benefits (Physical, Occupational and Respiratory Therapy)		
• Office location	20%	50%
Speech Therapy Benefits		
• Office location	20%	50%
Pregnancy and Maternity Care Benefits		
• Prenatal and postnatal Physician office visits (For inpatient hospital services, see "Hospitalization Services.")	20%	50%
Family Planning Benefits		
• Counseling and consulting[12]	No Charge (Not subject to the Calendar-Year Deductible)	Not Covered
• Elective abortion[13]	20%	Not Covered
• Tubal ligation	No Charge (Not subject to the Calendar-Year Deductible)	Not Covered
• Vasectomy[13]	20%	Not Covered
Diabetes Care Benefits		

• Devices, equipment, and non-testing supplies (for testing supplies see Outpatient Prescription Drug Benefits.)	20%	50%
• Diabetes self-management training (If billed by your provider, you will also be responsible for the office visit copayment)	20%	50%
Care Outside of Plan Service Area (Benefits provided through the 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)		
• Within US: BlueCard Program	See Applicable Benefit	See Applicable Benefit
• Outside of US: BlueCard Worldwide	See Applicable Benefit	See Applicable Benefit
Optional Benefits Optional dental, vision, substance abuse treatment, infertility and hearing aid benefits are available. If your employer purchased any of these benefits, a description of the benefit is provided separately.		

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 Deductible and copayments marked with this footnote 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 Plan Contract for exact terms and conditions of coverage.

3 Participating non Hospital based ("freestanding") outpatient X-ray, pathology and laboratory facilities centers may not be available in all areas. Regardless of their availability, you can obtain outpatient X-ray, pathology and laboratory services from a hospital or an ambulatory surgery center affiliated with a hospital, with payment according to your health plan's hospital services benefits.

4 Participating ambulatory surgery facilities centers may not be available in all areas. Regardless of their availability, you can obtain outpatient surgery services from a hospital or an ambulatory surgery center affiliated with a hospital, with payment according to your health plan's hospital services benefits.

5 Bariatric surgery is covered when pre-authorized by the Plan. 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 for bariatric services from non-preferred providers. In addition, if prior authorized by the Plan, 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.

6 The maximum allowed charges for non-emergency hospital services received from a non-preferred hospital is $600 per day. Members are responsible for 50% of this $600 per day, plus all charges in excess of $600.

7 Services may require prior authorization by the Plan. When services are prior authorized, members pay the preferred or participating provider amount.

8 Mental health services are accessed through Blue Shield's Mental Health Service Administrator (MHSA) - using Blue Shield's MHSA participating and non-participating providers. Only Blue Shield MHSA contracted providers are administered by the Blue Shield MHSA. Behavioral health services rendered by non-participating providers are administered by Blue Shield. 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 and Plan Contract.

9 Inpatient services for acute detoxification are covered under the medical benefit; see hospitalization services for benefit details. Services for medical acute detoxification are accessed through Blue Shield using Blue Shield's preferred providers or non-preferred providers.

10 Out of network home health care, home infusion and hospice services are not covered unless pre-authorized. When these services are pre-authorized, the member pays the Preferred Provider copayment.

11 All outpatient chiropractic visits accrue to the calendar-year visit maximum regardless of whether the plan deductible has been met.

12 Includes insertion of IUD as well as injectable contraceptives for women.

13 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.

14 **Optional 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."**

Plan designs may be modified to ensure compliance with state and federal requirements.

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