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

Shield Spectrum PPO Plan 1500
Blue Shield Life PPO Plan 1500

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/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. For all boxes without shading, you are responsible for all charges up to the allowable amount or billed charges until the deductible is met. At that point, you will be responsible for the copayment or coinsurance noted in the chart below when accessing preferred and non-preferred providers. **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.

Blue Shield of California and Blue Shield of California Life & Health Insurance Company each offer a PPO Plan 1500. The plan benefits and rates are identical. Please call (800) 431-2809 for more information.

DEDUCTIBLE*	$1,500 ($3,000 Family)
COPAYMENTS	$40 with Preferred Providers Not applicable with Non-Preferred Providers
PERCENTAGE COPAYMENTS	30% with Preferred **Choice** Hospitals 40% with Preferred **Affiliate** Hospitals 50% with Non-Preferred Providers
CALENDAR-YEAR COPAYMENT/ COINSURANCE MAXIMUM (Does not include the plan deductible. Some services do not apply.)	Services with Preferred **Choice** Providers**: $4,500 ($9,000 Family) Services with All Providers: $6,500 ($13,000 Family)
LIFETIME MAXIMUM	$6,000,000
TOTAL ANNUAL OUT-OF-POCKET COSTS	Deductible + copayment maximum

* Benefits for covered brand-name drugs are subject to a separate $250 brand-name drug deductible per person.
** This copayment/coinsurance maximum also includes copayments for services 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, asthma self-management training	$40[2]	50%
– Allergy testing and treatment	30%	50%
PREVENTIVE CARE		
– Annual Routine Physical Exam, Well-Baby care office visits and Gynecological exam (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)	$40[2]	Not Covered
OUTPATIENT SERVICES		
– Non-Emergency services and procedures, Outpatient surgery in 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]

COVERED SERVICES (Subject to the plan deductible, unless noted)	MEMBER COPAYMENTS With Preferred Providers,[1] you pay	With Non-Preferred Providers,[1] you pay
– 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%
HOSPITALIZATION SERVICES		
– Inpatient physician visits and consultations, surgeons and assistants, and anesthesiologists	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, semiprivate room and board, services and supplies, and subacute care not resulting in admission	30%/visit	30%/visit
– ER Physician visits[4]	30%	30%
AMBULANCE SERVICES (Surface or Air)[5]	30%	30%
PRESCRIPTION DRUG COVERAGE[6] (outpatient; brand-name drugs are subject to a $250 brand-name drug deductible per person, per calendar year; includes oral contraceptives, diaphragms, diabetic testing supplies, asthma inhalers and inhaler spacers)	**At Participating Pharmacies** (up to a 30-day supply)	**Mail Service Prescriptions** (up to a 60-day supply)
– Generic formulary drugs	$7/prescription[2]	$14/prescription[2]
– Formulary brand-name drugs[‡,7]	$25 + 10%/prescription (maximum copayment of $60 per prescription)[2]	$50 + 10%/prescription (maximum copayment of $90 per prescription)[2]
– Non-formulary brand-name drugs[‡,7]	$45 + 10%/prescription (maximum copayment of $100 per prescription)[2]	$75 + 10%/prescription (maximum copayment of $150 per prescription)[2]
– Home Self-Administered Injectables[8]	30%[2]	Not Covered
DURABLE MEDICAL EQUIPMENT		
– Prosthetic Appliances, Home Medical Equipment, Asthma Nebulizers (including face masks and tubing), Peak Flow Monitors and Orthotic Equipment[9]	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%
– Outpatient visits for severe mental health conditions	$40[2]	50%
– 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
	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%	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
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[2]	Not Covered
Rehabilitation Services		
– Physical, occupational, or respiratory therapy received in a provider's office or outpatient department of a hospital	30%	50%
Chiropractic Services (up to 12 visits per calendar year)		
– Received from a chiropractor	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%[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	$40[2]	50%
– Diabetes Care Supplies	30%	50%
Dental Services and Life Insurance (Optional dental benefits and life insurance are available.)		

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 or coinsurance in addition to any charges above allowable amounts. The coinsurance/copayment percentage indicated is a percentage of the allowable 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 or coinsurance plus any charges that exceed Blue Shield's allowable amount. Charges above the allowable amount do not count toward the plan deductible or copayment/coinsurance 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, copayment, coinsurance 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/coinsurance maximum and will continue to be charged once the copayment maximum 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 percent, 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. Except for covered emergencies, 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 **mylifepath.com.**

7 If a member requests a brand-name drug or the physician indicates Dispense As Written (DAW) for a prescription, when an equivalent generic drug is available, and the brand-name drug deductible has been satisfied, the member pays the generic copayment plus the difference between the brand and generic drug cost. Member pays a copayment plus 10 percent for formulary brand-name drugs. The 10 percent members' responsibility is calculated by taking Blue Shield's contracted rate, minus the copayment, and then taking 10 percent of the remaining amount.

8 Home self-administered injectables are available through pharmacies designated in a specialty network. They are only covered when obtained from a pharmacy designated in a specialty network, 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 *Evidence of Coverage* (EOC)/ *Certificate of Insurance* (COI).

11 Blue Shield has contracted with a specialized healthcare 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.