

# Shield Spectrum PPO<sup>SM</sup> Savings Plus

3000 Individual/6000 Family

City of Modesto

(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:** For preferred provider coverage, members must first meet their deductible and calendar-year copayment amount before benefits are paid at 100%. While their annual deductible is satisfied by covered services received from both preferred and non-preferred providers, if members receive services from non-preferred providers, they must pay the copay percentage amount listed until the calendar-year copayment maximum for non-preferred providers is met before Blue Shield covers 100% of the allowed amount from non-preferred providers.

Effective August 1, 2009

<b>DEDUCTIBLES</b>	<b>Preferred Providers<sup>1</sup></b>	<b>Non-Preferred Providers<sup>1</sup></b>
<b>Calendar-year deductible</b> (All providers combined) <small>(Note: For individual on family coverage plan, enrollee can receive benefits for covered services once individual deductible is met.)</small>	\$3,000 per individual/\$6,000 per family	
<b>Calendar-year out-of-pocket maximum<sup>1</sup></b> (Includes the plan deductible) <small>(Note: For individual on family coverage plan, enrollee can receive 100% benefits for covered services once individual out-of-pocket maximum is met.)</small>	\$3,000 per individual/ \$6,000 per family	\$5,000 per individual/ \$10,000 per family
<b>LIFETIME MAXIMUM</b>	\$6,000,000	
<b>Covered Services</b>	<b>Member Copayment</b>	
	<b>Preferred Providers<sup>1</sup></b>	<b>Non-Preferred Providers<sup>1</sup></b>
<b>PROFESSIONAL SERVICES</b>		
<b>Physician services</b>		
• Physician and specialist office visits	No charge	50%
• Allergy testing or treatment	No charge	50%
<b>Laboratory, X-rays and diagnostics</b>	No charge	50%
<b>Preventive care (Not subject to the plan's calendar-year deductible)</b>		
• Annual physical exam office visit (One per calendar year, age 3 and older), immunizations and vaccinations	No charge <sup>2</sup>	Not covered
• Laboratory, including mammogram and Pap test screening or other FDA-approved cervical cancer screening tests	No charge <sup>2</sup>	Not covered
<b>OUTPATIENT SERVICES</b>		
<small>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.</small>		
• Outpatient surgery performed in a Participating Ambulatory Surgery Center <sup>3</sup> (ASC)	No charge	50%
• Outpatient surgery in hospital/facility	No charge	50%
• Outpatient treatment and necessary supplies	No charge	50%
• Bariatric Surgery <sup>5</sup> (pre-authorization required; medically necessary surgery for weight loss, for morbid obesity only)	No charge	50%
<b>HOSPITALIZATION SERVICES</b>		
<b>Inpatient services – non-emergency</b>		
• Inpatient physician services	No charge	50%
• Semi-private room and board, medically necessary services and supplies	No charge	50% <sup>4</sup>
• Bariatric Surgery <sup>5</sup> (pre-authorization required; medically necessary surgery for weight loss, for morbid obesity only)	No charge	50% <sup>4</sup>
<b>Skilled nursing facility (SNF) services<sup>6</sup></b> <small>(Combined maximum of up to 100 preauthorized days per calendar year; semi-private accommodations)</small>		
• Freestanding SNF	No charge	No charge with prior authorization <sup>6</sup>
• Hospital SNF unit	No charge	50% <sup>4</sup>
<b>EMERGENCY HEALTH COVERAGE</b>		
• ER facility services (ER facility copay does not apply if the member is admitted directly from the ER for inpatient services.)	No charge	No charge
• Inpatient facility services (when the member is admitted directly from the ER)	No charge	No charge
• Emergency room physician visits	No charge	No charge

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<b>AMBULANCE SERVICES</b>	No charge	No charge
<b>PRESCRIPTION DRUG COVERAGE</b> <sup>7, 8, 9, 10, 11, 12</sup> (Subject to deductible; includes oral contraceptives and diaphragms)		
<b>Retail prescriptions</b> (For up to a 30-day supply)	Participating Pharmacy	Non-Participating Pharmacy
• Generic drugs	No charge	No charge
• Formulary brand-name drugs	No charge	No charge
• Non-formulary brand-name drugs	No charge	No charge
<b>Mail service prescriptions</b> (For up to a 90-day supply)		
• Generic drugs	No charge	Not covered
• Formulary brand-name drugs	No charge	Not covered
• Non-formulary brand-name drugs	No charge	Not covered
<b>Home self-administered injectable medications</b> (Available at specialty pharmacy network only)	No charge	Not covered through mail service benefit
<b>PROSTHETICS/ORTHOTICS</b>	No charge	50%
(Equipment and devices only. Separate office visit copay may apply)		
<b>DURABLE MEDICAL EQUIPMENT</b>	No charge	50%
(Plan payment up to \$2,000 maximum per calendar year)		
<b>MENTAL HEALTH SERVICES (PSYCHIATRIC)</b> <sup>13</sup>	<b>MHSA Participating Providers</b> <sup>1</sup>	<b>MHSA Non-Participating Providers</b> <sup>1</sup>
• Inpatient hospital facility services	No charge	50% <sup>4</sup>
• Outpatient visits for severe mental health conditions	No charge	50%
• Outpatient visits for non-severe mental health conditions (Up to 20 visits per calendar year combined with outpatient chemical dependency visits) <sup>15</sup>	No charge	Not covered
<b>CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)</b> <sup>13</sup> , <b>Please see footnote 14</b>	<b>MHSA Participating Providers</b> <sup>1</sup>	<b>MHSA Non-Participating Providers</b>
• Inpatient services for medical acute detoxification	See "Hospitalization Services"	See "Hospitalization Services"
• Outpatient visits (Up to 20 visits per calendar year combined with outpatient non-severe mental health visits) <sup>15</sup>	No charge	Not covered
<b>HOME HEALTH SERVICES</b> <sup>16</sup>	<b>Preferred Providers</b> <sup>1</sup>	<b>Non-Preferred Providers</b> <sup>1</sup>
• Home health (Up to 100 prior authorized visit maximum per calendar year)	No charge	Not covered <sup>16</sup>
• Home infusion care/home injectable treatment	No charge	Not covered <sup>16</sup>
<b>OTHER</b>		
<b>Hospice</b> <sup>16</sup>		
• Routine home care	No charge	Not covered <sup>16</sup>
• Inpatient respite care	No charge	Not covered <sup>16</sup>
• 24 hour continuous home care	No charge	Not covered <sup>16</sup>
• General inpatient care	No charge	Not covered <sup>16</sup>
<b>Pregnancy and maternity care</b>		
• Prenatal and postnatal professional (physician) services (For all necessary inpatient hospital services, see "Hospitalization Services.")	No charge	50%
<b>Well-baby care</b> (From birth through and including age 2) (Not subject to the calendar-year deductible)		
• Office visits and consultations	No charge <sup>2</sup>	Not covered
• Immunizations	No charge <sup>2</sup>	Not covered
• Laboratory screenings	No charge <sup>2</sup>	Not covered
<b>Family planning</b>		
• Family planning counseling	No charge	Not covered
• Tubal ligation, elective abortion, vasectomy <sup>17</sup>	No charge	Not covered
<b>Rehabilitative therapy services</b>		
• Outpatient visits	No charge	50%
<b>Acupuncture services</b>	Not covered	Not covered
<b>Chiropractic services</b> <sup>15</sup> (Up to 20 visits per calendar year)		
• Chiropractic services provided by a chiropractor	No charge	50%
<b>Diabetes care</b>		
• Equipment, devices and supplies	No charge	50%
• Self-management training and education (If billed by your provider, you will also be responsible for the office visit copayment)	No charge	50%

Covered out-of-state services (Benefits provided through the BlueCard® Program)  
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.

See Applicable Benefit

See Applicable Benefit

### Optional Benefits

Optional dental, vision, inpatient substance abuse treatment or infertility 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 allowed 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 in excess of the allowable amount do not count toward the calendar-year deductible or out-of-pocket maximum. Payments applied to your Calendar Year Deductible accrue towards the Maximum Calendar Year Out-of-Pocket Responsibility.
- 2 The preventive care and well-baby care office visit are not subject to the plan deductible. Other covered non-preventive services received during or in connection with the office visit are subject to the plan deductible and the applicable copayment percentage.
- 3 Participating ambulatory surgery 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.
- 4 The maximum allowed charge for non-emergency hospital services received from a non-preferred hospital is \$600 per day. Members are responsible for 50 percent of this \$600 per day, plus all charges in excess of \$600. Payments that exceed the allowed charge do not count toward the calendar-year out-of-pocket maximum, and continue to be charged after it is reached.
- 5 Bariatric surgery is covered when pre-authorized by Blue Shield. 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 Blue Shield of California, 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 Services may require prior authorization by Blue Shield. When services are prior authorized, members pay the preferred or participating provider amount.
- 7 This plan's prescription drug coverage is on average equivalent to or better than the standard benefit set by the federal government for Medicare Part D (also called "creditable" coverage). Since this plan's prescription drug coverage is creditable, you do not have to enroll in Medicare Part D while you maintain this coverage; however, you should be aware that if you have a subsequent break in this coverage of 63 days or more before enrolling in Medicare Part D you could be subject to payment of higher Medicare Part D premiums.
- 8 If the Subscriber requests a Brand Name Drug when a Generic Drug equivalent is available, the Subscriber is responsible for paying the difference between the cost to Blue Shield of the Brand Name Drug and its Generic Drug equivalent, as well as the applicable Generic Drug Copayment. This difference in cost that the Subscriber must pay is not applied to the Calendar Year Deductible and is not included in the Calendar Year maximum out-of-pocket responsibility calculations.
- 9 For the Outpatient Drugs benefit, covered drugs obtained from Non-Participating Pharmacies will be subject to and accrue to the deductible and the copay maximum for Preferred Providers.
- 10 Home self-administered injectable drugs are covered only when dispensed by select pharmacies in the Specialty Pharmacy Network unless Medically Necessary for a covered emergency.
- 11 Selected formulary and non-formulary drugs and most home self-administered injectables require prior authorization by Blue Shield for Medical Necessity, and when effective, lower cost alternatives are available.
- 12 Please note that if you switch from another plan, your prescription drug deductible credit from the previous plan during the calendar year, if applicable, will not carry forward to your new plan.
- 13 Mental health and chemical dependency services, other than medical acute detoxification, 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. 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.
- 14 **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."**
- 15 All outpatient non-severe mental health, outpatient substance abuse and chiropractic visits accrue to the calendar-year visit maximum regardless of whether the plan deductible has been met.
- 16 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.
- 17 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.

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