

Shield Spectrum PPO Plan 1500

Blue Shield Life PPO Plan 1500



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

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/POLICY FOR INDIVIDUALS AND FAMILIES SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

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

Shield Spectrum PPO Plan 1500	
DEDUCTIBLE*	\$1,500 (\$3,000 Family)
COPAYMENTS	\$40 with Preferred Hospitals Not applicable with Non-Preferred Providers
PERCENTAGE COPAYMENTS	30% with Preferred 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 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 \$500 brand-name drug deductible per person.	

Plan benefits that are available before you need to meet the medical plan deductible are shown below in a shaded box. For all benefits 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.

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	\$40 ²	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%	50% ^{2,3}
– Outpatient or Out-of-Hospital X-ray and Laboratory	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%	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	30%	30%

COVERED SERVICES (subject to the plan deductible, unless noted)	MEMBER COPAYMENTS	
	With Preferred Providers, ¹ you pay	With Non-Preferred Providers, ¹ you pay
AMBULANCE SERVICES (Surface or Air)	30%	30%
PRESCRIPTION DRUG COVERAGE⁴ (outpatient; brand-name drugs are subject to a \$500 brand-name drug deductible per person, per calendar year. Prescription coverage differs for Home Self-Injectables. Please review the EOC/Policy before you purchase the plan.)	At Participating Pharmacies (up to a 30-day supply)	Mail Service Prescriptions (up to a 60-day supply)
– Generic formulary drugs	\$10/prescription ²	\$20/prescription ²
– Formulary brand-name drugs	\$35/prescription ²	\$70/ prescription ²
– Non-formulary brand-name drugs	\$50 or 50%/prescription, whichever is greater (maximum copayment of \$150 per prescription) ²	\$100 or 50%, whichever is greater (maximum copayment of \$300 per prescription) ²
DURABLE MEDICAL EQUIPMENT⁵	30%	50%
	With MHSa Participating Providers,¹ you pay	With MHSa Non-Participating Providers,¹ you pay
MENTAL HEALTH SERVICES⁶		
– 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) ⁶		
– Inpatient Hospital Facility Services for medical acute detoxification	30%	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
OTHER		
Pregnancy and Maternity Care		
– Outpatient prenatal and postnatal care	30%	50%
– Delivery and all necessary inpatient hospital services	30%	50% ^{2,3}
Family Planning		
– Consultations, tubal ligation, vasectomy, elective abortion	30%	Not Covered
Rehabilitation Services		
– Physical, occupational, or respiratory therapy	30%	50%
Chiropractic Services (up to 12 visits per calendar year)	50% up to \$25 (member responsible for all charges over \$25)	Not Covered
Out-of-State Services (full plan benefits covered nationwide with the BlueCard program)	30% with BlueCard Participating Providers	50% with all other providers

Please Note: Benefits are subject to modification for subsequently enacted state or federal legislation.

- Member is responsible for fixed dollar or percentage copayment in addition to any charges above allowable amounts. The copayment/coinsurance percentage indicated is a percentage of the allowed 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 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.
- These copayments do not count toward the copayment/coinsurance maximum and will continue to be charged once the copayment maximum is reached.
- 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.
- 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 cost difference between the brand-and generic drug. The \$150/300 max/Rx for non-formulary brand-name drugs does not apply to Blue Shield Life Shield Spectrum PPO Plan 1500.
- 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.
- Blue Shield of California and Blue Shield have 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 providers.

Please Note: This document is not a contract and should only be distributed with a presale disclosure document that explains general plan exclusions and limitations. Both documents should be read together. For actual complete benefit descriptions, terms and conditions and limitations of the health plan, please read the *Evidence of Coverage and Health Service Agreement (EOC) Policy for Individuals and Families (Policy)*. For a complete description of the PPO Plan 1500, you can request a copy of the EOC/Policy by calling (800) 431-2809.