

Victor Treatment Center
 Shield Spectrum PPOSM Savings Plus
 3000 Individual/6000 Family
 Benefit Summary (For groups of 300 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 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 copayment 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 April 1, 2011

DEDUCTIBLES	Preferred Providers¹	Non-Preferred Providers¹
Calendar year Medical Deductible (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
Calendar year out-of-pocket maximum¹ (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
LIFETIME MAXIMUM	None	
Covered Services	Member Copayment	
PROFESSIONAL SERVICES	Preferred Providers¹	Non-Preferred Providers¹
Professional (physician) benefits		
• Physician and specialist office visits	No charge	50%
• Outpatient X-ray, pathology and laboratory	No charge	50%
Allergy testing and treatment benefits		
• Office visits (includes visits for allergy serum injections)	No charge	50%
Preventive health benefits		
• Annual routine physical examination office visit: including the physical examination office visit, routine eye/ear screening for members through age 18 and pediatric and adult immunizations and the immunization agent.	No charge <small>(Not subject to the Calendar-Year Deductible)</small>	Not covered
• Annual routine gynecological office visit: including the gynecological examination office visit, routine mammography, routine Papanicolaou (Pap) test or other FDA approved cervical cancer screening test, human papillomavirus (HPV) screening tests (One per calendar year)	No charge <small>(Not subject to the Calendar-Year Deductible)</small>	Not covered
• Routine laboratory services, including well baby laboratory services	No charge <small>(Not subject to the Calendar-Year Deductible)</small>	Not covered
• Well baby office visit: including well baby examination office visit, pediatric immunizations and the immunization agent, well baby vision and hearing screening	No charge <small>(Not subject to the Calendar-Year Deductible)</small>	Not covered
OUTPATIENT SERVICES		
Hospital benefits (facility services) <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 an ambulatory surgery center ²	No charge	50%
• Outpatient surgery in a hospital	No charge	50%
• Outpatient services for treatment of illness or injury and necessary supplies (Except as described under "Rehabilitation benefits")	No charge	50%
• Bariatric surgery ⁴ (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity)	No charge	50%
HOSPITALIZATION SERVICES		
Hospital benefits (facility services)		
• Inpatient physician benefits	No charge	50%
• Inpatient non-emergency facility services (semi-private room and board, medically necessary services and supplies)	No charge	50% ³
• Bariatric surgery ⁴ (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity)	No charge	50% ³

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Skilled nursing facility benefits⁵ (Combined maximum of up to 100 preauthorized days per calendar year; semi-private accommodations)		
• Services by a free-standing skilled nursing facility	No charge	No charge with prior authorization ⁵
• Skilled nursing facility unit of a hospital	No charge	50% ³
EMERGENCY HEALTH COVERAGE		
• Emergency room services not resulting in admission (ER Facility copay does not apply if the member is admitted directly from the ER for inpatient services.)	No charge	No charge
• Emergency room services resulting in admission (when the member is admitted directly from the ER)	No charge	No charge
• Emergency room physician services	No charge	No charge
AMBULANCE SERVICES		
• Emergency or authorized transport	No charge	No charge
PRESCRIPTION DRUG COVERAGE^{6, 7, 8, 9, 10, 11, 12} (Subject to deductible; includes oral contraceptives, diaphragms, and covered diabetic drugs and testing supplies)		
Outpatient Prescription Drug Benefits	Participating Pharmacy	Non-Participating Pharmacy
Retail prescriptions (For up to a 30-day supply)		
• Formulary generic drugs	No charge	No charge
• Formulary brand name drugs	No charge	No charge
• Non-formulary brand name drugs	No charge	No charge
Mail service prescriptions (For up to a 90-day supply)		
• Formulary generic drugs	No charge	Not covered
• Formulary brand name drugs	No charge	Not covered
• Non-formulary brand name drugs	No charge	Not covered
Specialty Pharmacies		
• Specialty drugs	No charge	Not covered
PROSTHETICS/ORTHOTICS		
• Prosthetic equipment and devices (Separate office visit copay may apply)	No charge	50%
• Orthotic equipment and devices (Separate office visit copay may apply)	No charge	50%
DURABLE MEDICAL EQUIPMENT		
• Durable medical equipment	No charge	50%
MENTAL HEALTH SERVICES (PSYCHIATRIC)¹³		
• Inpatient hospital services	No charge	50% ³
• Outpatient mental health services	No charge	50%
CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)¹⁵		
• Chemical dependency and substance abuse services	Not Covered	Not Covered
HOME HEALTH SERVICES¹⁶		
• Home health care agency services (Up to 100 prior authorized visit maximum per calendar year)	No charge	Not covered ¹⁶
• Home infusion/home injectable therapy provided by a home infusion agency	No charge	Not covered ¹⁶
OTHER		
Hospice program benefits¹⁶		
• Routine home care	No charge	Not covered ¹⁶
• Inpatient respite care	No charge	Not covered ¹⁶
• 24 hour continuous home care	No charge	Not covered ¹⁶
• General inpatient care	No charge	Not covered ¹⁶
Chiropractic benefits¹⁴		
• Chiropractic services – provided by a chiropractor (Up to 20 visits per calendar year)	No charge	50%
Acupuncture benefits		
• Acupuncture	Not covered	Not covered
Rehabilitation benefits (physical, occupational and respiratory therapy)		
• Office location	No charge	50%
Speech therapy benefits		
• Office location	No charge	50%
Pregnancy and maternity care benefits		
• Prenatal and postnatal physician office visits (For inpatient hospital services, see "Hospitalization Services.")	No charge	50%

Family planning benefits

• Counseling and consulting	No charge	Not covered
• Tubal ligation ¹⁷	No charge	Not covered
• Elective abortion ¹⁷	No charge	Not covered
• Vasectomy ¹⁷	No charge	Not covered

Diabetes care benefits

• Devices, equipment and non-testing supplies (For testing supplies, see "Outpatient Prescription Drug Benefits.")	No charge	50%
• Diabetes self-management training (If billed by your provider, you will also be responsible for the office visit copayment)	No charge	50%

Care outside of plan service area (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.

• 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 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 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.
- 3 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.
- 4 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 plan contract for further benefit details.
- 5 Services may require prior authorization by Blue Shield. When services are prior authorized, members pay the preferred or participating provider amount.
- 6 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.
- 7 If the member requests a Brand Name Drug when a Generic Drug equivalent is available, the member 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 member must pay is not applied to the Calendar Year Deductible and is not included in the Calendar Year maximum out-of-pocket responsibility calculations.
- 8 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.
- 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 Specialty 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 require prior authorization by Blue Shield for Medical Necessity, and when effective, lower cost alternatives are available.
- 12 Specialty Drugs are specific Drugs used to treat complex or chronic conditions which usually require close monitoring such as multiple sclerosis, hepatitis, rheumatoid arthritis, cancers, and other conditions that are difficult to treat with traditional therapies. Specialty Drugs are listed in the Blue Shield Outpatient Drug Formulary. Specialty Drugs may be self-administered in the home by injection by the patient or family member (subcutaneously or intramuscularly), by inhalation, orally or topically. Infused or Intravenous (IV) medications are not included as Specialty Drugs. These Drugs may also require special handling, special manufacturing processes, and may have limited prescribing or limited pharmacy availability. Specialty Drugs must be considered safe for self-administration by Blue Shield's Pharmacy & Therapeutics Committee, be obtained from a Blue Shield Specialty Pharmacy and may require prior authorization for Medical Necessity by Blue Shield.
- 13 Mental health services are accessed using Blue Shield's participating and non-participating providers. For a listing of severe mental illnesses, including serious emotional disturbances of a child, and other benefit details, please refer to the plan contract.
- 14 Chiropractic visits accrue to the calendar-year visit maximum regardless of whether the plan deductible has been met.
- 15 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.
- 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

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