



Blue Shield
of California

Shield Spectrum PPO Plans

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Giving you the freedom to choose your healthcare provider and the deductible that's right for you



The Shield Spectrum PPOSM Plans offer you protection from major healthcare expenses along with the flexibility to visit the doctors and specialists you want to see. When you receive care from Blue Shield PPO preferred providers, your out-of-pocket costs are less. Advantages of the plans include:

- One of California's largest PPO provider networks, with over 45,000 physicians and more than 350 hospitals
- Many services with a fixed dollar or percentage copayment before you meet the deductible
- Wide range of annual deductibles; when two or more people are covered, each covered individual in the family also has his or her own individual deductible, in case only one person needs expensive medical care
- Copayment /coinsurance maximums on most services to help contain costs; your family copayment maximums are only twice the individual amounts, no matter how many people are covered on the plan
- Choose from a variety of deductibles to meet your healthcare needs

Whether you visit the doctor often or infrequently, you know the importance of having coverage to help protect you from unexpected medical expenses. With Blue Shield's Shield Spectrum PPO Plans you have the freedom to see the doctor you want, as well as a wide range of benefits and deductible levels to best fit your needs.

Higher deductibles vs. Lower deductibles

Our family of PPO plans offers a range of deductibles that allows you to choose what works best for you. For individuals who visit the doctor more frequently, a plan that features lower deductibles may be particularly attractive.

Conversely, a higher deductible health plan can keep expenses down for people who infrequently visit a doctor. Members who are in relatively good health may find that higher deductibles allow them to maintain coverage for unexpected health events, such as a broken leg, while keeping monthly dues lower.

The Value of Blue Shield Coverage

As a Blue Shield member, you will have coverage from a trusted organization that has provided affordable, flexible and dependable healthcare plans to millions of Californians. We have developed strong relationships with hospitals and physicians, which means you will benefit from the rates we've negotiated for medical services with providers instead of being subject to any fees they may choose to charge.

Additional Services

Blue Shield offers a wide variety of value-added services to help our members make better-informed healthcare decisions and manage their health plan benefits more effectively. The *Lifepath Advisers*SM program offers assistance for professional and personal concerns 24 hours a day by connecting you with a registered nurse, master's level counselor or work-life balance resources. Through our innovative Web site, mylifepath.com, members have 24-hour access to resources such as My Health Plan to find out about their specific plan benefits and services, Pharmacy to compare the costs of generic versus brand-name drugs and *Lifepath Decision Guide*SM to find out about treatment options for a diagnosed condition.

Visit us at mylifepath.com

Individual and Family Plans

An Independent Member of the Blue Shield Association

Shield Spectrum PPO Plan 2000

Blue Shield Life PPO Plan 2000

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 2000. Please call (800) 431-2809 for more information.

Shield Spectrum PPO Plan 2000	
DEDUCTIBLE*	\$2,000 (\$4,000 Family)
COPAYMENTS	\$45 with Preferred Providers 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: \$5,000 (\$10,000 Family) Services with All Providers: \$7,000 (\$14,000 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	\$45 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)	\$45 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-Injectibles. 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 MHS A Participating Providers,¹ you pay	With MHS A 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	\$45 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 refer to page 10 for list of footnotes.

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/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-Injectibles. 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 MHPA Participating Providers, ¹ you pay	With MHPA 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 refer to page 10 for list of footnotes.

Shield Spectrum PPO Plan 750

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

Shield Spectrum PPO Plan 750	
DEDUCTIBLE*	\$750 (\$1,500 Family)
COPAYMENTS	\$35 with Preferred Providers Not applicable with Non-Preferred Providers
PERCENTAGE COPAYMENTS	30% with Preferred Hospitals 50% with Non-Preferred Providers
CALENDAR-YEAR COPAYMENT MAXIMUM (Does not include the plan deductible. Some services do not apply.)	Services with Preferred Providers: \$4,000 (\$8,000 Family) Services with All Providers: \$6,000 (\$12,000 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 \$250 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	\$35 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)	\$35 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%
AMBULANCE SERVICES (Surface or Air)	30%	30%

COVERED SERVICES

MEMBER COPAYMENTS

(Subject to the plan deductible, unless noted)

PRESCRIPTION DRUG COVERAGE⁴

(outpatient; brand-name drugs are subject to a \$250 brand-name drug deductible per person, per calendar year. Prescription coverage differs for Home Self-Injectibles. Please review the EOC 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 MHA Participating Providers,¹
you pay**

**With MHA 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	\$35 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
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Rehabilitation Services

– Physical, occupational, or respiratory	30%	50%
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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 refer to page 10 for list of footnotes.

Shield Spectrum PPO Plan 500

Uniform Health Plan Benefits & Coverage Matrix

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Shield Spectrum PPO Plan 500	
DEDUCTIBLE*	\$500 (\$1,000 Family)
COPAYMENTS	\$30 with Preferred Providers Not applicable with Non-Preferred Providers
PERCENTAGE COPAYMENTS	25% with Preferred Hospitals 50% with Non-Preferred Providers
CALENDAR-YEAR COPAYMENT MAXIMUM (Does not include the plan deductible. Some services do not apply.)	Services with Preferred Providers: \$3,500 (\$7,000 Family) Services with All Providers: \$5,000 (\$10,000 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.	

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	\$30 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)	\$30 ²	Not Covered
OUTPATIENT SERVICES		
– Non-Emergency services and procedures, Outpatient surgery in hospital	25%	50% ^{2,3}
– Outpatient or Out-of-Hospital X-ray and Laboratory	25%	50%
HOSPITALIZATION SERVICES		
– Inpatient physician visits and consultations, surgeons and assistants, and anesthesiologists	25%	50%
– Inpatient semiprivate room and board, services and supplies, and subacute care	25%	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	25%/visit	25%/visit
– ER Physician visits	25%	25%
AMBULANCE SERVICES (Surface or Air)	25%	25%

COVERED SERVICES

MEMBER COPAYMENTS

(subject to the plan deductible, unless noted)

PRESCRIPTION DRUG COVERAGE⁴

(outpatient; brand-name drugs are subject to a \$250 brand-name drug deductible per person, per calendar year. Prescription coverage differs for Home Self-Injectibles. Please review the EOC 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

25%

50%

**With MHA Participating Providers,¹
you pay**

**With MHA Non-Participating Providers,¹
you pay**

MENTAL HEALTH SERVICES⁶

– Inpatient Hospital Facility Services	25%	50% ^{2,3}
– Inpatient Physician Services	25%	50%
– Outpatient visits for severe mental health conditions	\$30 ²	50%
– Outpatient visits for non-severe mental health conditions (up to 20 visits per calendar year combined with chemical dependency visits)	25%	Not Covered

CHEMICAL DEPENDENCY SERVICES

(Substance Abuse)⁶

– Inpatient Hospital Facility Services for medical acute detoxification	25%	50% ^{2,3}
– Inpatient Physician Services for medical acute detoxification	25%	50%
– Outpatient visits (up to 20 visits per calendar year combined with non-severe mental health visits)	25%	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.)

25%

Not Covered

OTHER

Pregnancy and Maternity Care

– Outpatient prenatal and postnatal care	25%	50%
– Delivery and all necessary inpatient hospital services	25%	50% ^{2,3}

Family Planning

– Consultations, tubal ligation, vasectomy, elective abortion	25%	Not Covered
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Rehabilitation Services

– Physical, occupational or respiratory therapy	25%	50%
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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)

25% with BlueCard Participating Providers

50% with all other providers

Please refer to page 10 for list of footnotes.

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

- 1 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.
- 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 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 Plans 2000 or 1500.
- 5 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.
- 6 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 Plans 2000-500, you can request a copy of the EOC/Policy by calling (800) 431-2809.

