

Hemet Unified School District
 Custom Shield Spectrum PPOSM
 Plan 150-90/70
 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 EVIDENCE OF COVERAGE, AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Blue Shield of California

Effective July 1, 2009

DEDUCTIBLES¹ (All providers combined; last quarter deductible carry-over applies)	Preferred Providers²	Non-Preferred Providers²
Calendar-year medical deductible	\$150 per individual \$400 per family	\$300 per individual \$750 per family
Calendar-year Copayment Maximum¹	\$500 per individual \$1,000 per family	\$2,200 per individual \$4,400 per family

LIFETIME MAXIMUM \$2,000,000

Covered Services **Member Copayment**

PROFESSIONAL SERVICES	Preferred Providers²	Non-Preferred Providers²
Physician services		
• Physician and specialist office visits	\$20/visit (Not subject to the Calendar-Year Deductible)	30%
• Laboratory and X-rays	10%	30%
• Allergy testing or treatment	10%	30%
• Diagnostic testing	10%	30%
Preventive care		
• Annual routine physical exam, eye/ear screenings and immunizations	\$10/visit (Not subject to the Calendar-Year Deductible)	Not covered
• Laboratory, including mammogram and Pap test screening or other FDA-approved cervical cancer screening tests (One per calendar year)	10% (Not subject to the Calendar-Year Deductible)	Not covered
Well-baby care		
• Office visits and consultations Includes: eye/ear screenings, immunizations, vaccinations	\$10/visit (Not subject to the Calendar-Year Deductible)	Not covered
• Laboratory	10%	Not covered

OUTPATIENT SERVICES

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 30% of this \$350 per day, plus all charges in excess of \$350.

• Outpatient surgery performed in a Participating Ambulatory Surgery Center ³ (ASC)	10%	30%
• Outpatient surgery in hospital/facility	10%	30%
• Outpatient treatment and necessary supplies	10%	30%
• Bariatric surgery (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity) ⁵	10%	30%

HOSPITALIZATION SERVICES

Inpatient services – non-emergency

• Inpatient physician services (Including pregnancy and maternity care)	10%	30%
• Semi-private room and board, medically necessary services and supplies	10%	30% ⁴
• Bariatric surgery (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity) ⁵	10%	30% ⁴

Skilled nursing facility (SNF) services⁶

• Freestanding SNF	10%	10% with prior authorization ⁶
• Hospital SNF unit	10%	30% ⁴

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EMERGENCY HEALTH COVERAGE		
• ER facility services (If ER services do not result in a direct admission the Calendar-Year Deductible does not apply)	\$50 + 10%	\$50 + 10%
• Inpatient facility services (when the member is admitted directly from the ER)	10%	10%
• Emergency room physician visits	10%	10%
AMBULANCE SERVICES		
	20% (Not subject to the Calendar-Year Deductible)	20% (Not subject to the Calendar-Year Deductible)
PROSTHETICS/ORTHOTICS		
(Equipment and devices only. Separate office visit copay may apply)	10%	30%
DURABLE MEDICAL EQUIPMENT		
	10%	30%
MENTAL HEALTH SERVICES (PSYCHIATRIC)⁷		
	Participating Providers²	Non-Participating Providers²
• Inpatient hospital facility services (Up to 20 days per calendar year combined with inpatient substance abuse)	10%	30% ⁴
• Outpatient visits for mental health conditions (Up to 50 visits per calendar year combined with outpatient chemical dependency visits) ⁹	50% (Not subject to the Calendar-Year Deductible)	50%
CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)⁷		
• Inpatient services for medical acute detoxification	See "Hospitalization Services"	See "Hospitalization Services"
• Inpatient hospital facility services (Up to 20 days per calendar year combined with inpatient mental health)	10%	30% ⁴
• Outpatient visits (Up to 50 visits per calendar year combined with outpatient mental health visits)	50% (Not subject to the Calendar-Year Deductible)	50%
HOME HEALTH SERVICES⁹		
	Preferred Providers²	Non-Preferred Providers²
• Home health	10%	Not covered ⁹
• Home infusion care	10%	Not covered ⁹
OTHER		
Hospice⁹		
• Routine home care	10%	Not covered ⁹
• Inpatient respite care	10%	Not covered ⁹
• 24 hour continuous home care	10%	Not covered ⁹
• General inpatient care	10%	Not covered ⁹
Alternative care⁸		
• Chiropractic services (Up to 26 visits per calendar year)	\$10/visit (Not subject to the Calendar-Year Deductible)	30%
• Acupuncture services (Up to 26 visits per calendar year)	\$20/visit (Not subject to the Calendar-Year Deductible)	\$20/visit (Not subject to the Calendar-Year Deductible)
Rehabilitative therapy services		
• Outpatient visits	10%	30%
Pregnancy and maternity care		
• Prenatal and postnatal professional (physician) services (For all necessary inpatient hospital services, see "Hospitalization Services.")	10%	30%
Family planning		
• Family planning counseling	\$20/visit (Not subject to the Calendar-Year Deductible)	Not covered
• Elective abortion, tubal ligation, vasectomy ¹⁰	10%	Not covered
Diabetes care		
• Equipment, devices and non-testing supplies	10%	30%
• Self-management training and education (If billed by your provider, you will also be responsible for the office visit copayment)	\$20/visit	30%
• Accident Benefit ¹⁰	Plan pays first \$500/injury, patient responsible for 10% thereafter	Plan pays first \$500/injury, patient responsible for 30% thereafter
Covered out-of-state benefits 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

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- 1 Deductible and copayments marked with a (1) do not accrue to calendar-year copayment maximum. Copayments and charges for services not accruing to the member's calendar-year copayment maximum continue to be the member's responsibility after the calendar-year copayment maximum is reached. Deductible does not apply toward the calendar-year maximum. Please refer to the Evidence of Coverage, the Disclosure Form and the Plan Contract for exact terms and conditions of coverage.
 - 2 Member is responsible for copayment in addition to any charges above allowable amounts. The copayment percentage indicated is a percentage of allowable 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 above the allowable amount do not count toward the calendar-year deductible or copayment maximum.
 - 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 \$1500 per day. Members are responsible for 30 percent of this \$1,500 per day, plus all charges in excess of \$1,500.
 - 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 Mental health, chemical dependency services and medical acute detoxification are accessed through Blue Shield using Blue Shield's preferred providers or non-preferred providers. For benefit details, please refer to the Evidence of Coverage or plan contract.
 - 8 All outpatient non-severe mental health, outpatient substance abuse, acupuncture and chiropractic visits accrue to the calendar-year visit maximum regardless of whether the plan deductible has been met.
 - 9 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.
 - 10 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