Shield Spectrum PPO

PPO 5000*

PPO 5500

* Underwritten by Blue Shield of California Life & Health Insurance Company.

Shield Spectrum PPOs feature comprehensive coverage with rich benefits for families and individuals seeking a robust health plan.

Is a Shield Spectrum PPO right for you?

Whether you are single or have a family, Shield Spectrum PPO℠ plans will provide you with comprehensive coverage for doctor visits, prescription drugs, and hospital care. Shield Spectrum PPOs make it easy to visit the doctors and specialists you want with our large provider network. Keep in mind, when you receive care from Blue Shield PPO network providers, your out-of-pocket costs are always lower.

Shield Spectrum PPO advantages
Two deductible amounts to choose from: $5,000 or $5,500.
Includes generic and brand-name prescription drug coverage.
Generic prescription drug coverage for as low as $10, and you don't need to meet a deductible.
Preventive care at no additional cost.
When two or more family members are on one plan, each covered individual has his or her own individual deductible, in case only one person needs expensive medical care.
Copayment/coinsurance maximums help contain costs, because your family maximum is only twice the individual amount, no matter how many people are covered.

Shield Spectrum PPO

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

	PPO 5000	PPO 5500
Deductible*	$5,000 ($10,000 family)	$5,500 ($11,000 family)
Coinsurance	30% with preferred providers 50% with non-preferred providers	35% with Preferred providers 50% with Non-preferred providers
Calendar-year copayment/ coinsurance maximum (includes the plan deductible – some services do not apply)	Services with preferred providers: $7,000 ($14,000 family) Services with all providers: $10,000 ($20,000 family)	Services with preferred providers: $7,500 ($15,000 family) Services with all providers: $10,000 ($20,000 family)
Lifetime maximum	No limit	No limit

- Plan benefits provided before you need to meet medical deductible are shown below with a dot. For all benefits without a dot, you are responsible for all charges up to the allowable amount or billed charges with preferred and non-preferred providers 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	Member copayments		
Subject to the plan deductible, unless noted.	**With preferred providers,[1] you pay**		**With non-preferred providers,[1] you pay**
	PPO 5000	**PPO 5500**	
Professional services			
Office visits	$35	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 preventive care exam)	$0 ●	$0 ●	Not covered
Outpatient services			
Non-emergency services and procedures	30%	35%	50%[2,3]
Outpatient surgery in hospital	30%	35%	50%[2,3]
Outpatient surgery performed in an ambulatory surgery center (ASC)	30%	35%	50%[2,4]
Outpatient or out-of-hospital X-ray and laboratory	30%	35%	50%
Hospitalization services			
Inpatient physician visits and consultations, surgeons and assistants, and anesthesiologists	30%	35%	50%
Inpatient semiprivate room and board, services and supplies, and subacute care	30%	35%	50%[2,3]
Bariatric surgery inpatient services (pre-authorization required: medically necessary surgery for weight loss, only for morbid obesity)[5]	30%	35%	50%[2,3]
Emergency health coverage			
Emergency room services ($100 copayment/visit waived if admitted as an inpatient)	30%	$100/visit + 35%	$100/visit + 35%
ER physician visits	30%	35%	35%
Ambulance services (surface or air)	30%	35%	35%

* Benefits for covered brand-name prescription drugs are subject to a separate brand-name drug deductible per person.

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Covered services	Member copayments		
Prescription drug coverage[6] (outpatient)	**At participating pharmacies** (up to a 30-day supply)		**Mail service prescriptions** (up to a 60-day supply)
	PPO 5000	**PPO 5500**	
Generic formulary drugs	$10/prescription[2] ●	$10/prescription[2] ●	$20/prescription[2] ●
Formulary brand-name drugs	$35/prescription[2]	$45/prescription[2]	**PPO 5000** $70/prescription[2] **PPO 5500** $90/prescription[2]
Non-formulary brand-name drugs	$50 or 50%/ prescription (whichever is greater)[2]	$60 or 50%/ prescription, whichever is greater (maximum copayment of $150 per prescription)[2]	**PPO 5000** $100 or 50%/ prescription, whichever is greater (maximum copayment of $300 per prescription)[2] **PPO 5500** $120 or 50%/ prescription, whichever is greater (maximum copayment of $300 per prescription)[2]
Brand-name drug deductible (brand-name drugs are subject to a brand-name drug deductible per person, per calendar year)	$500	$750	

	With preferred providers,[1] you pay		**With non-preferred providers,[1] you pay**
	PPO 5000	**PPO 5500**	
Durable medical equipment	30%	35%	50%
Mental health services[7]			
Inpatient hospital facility services	30%	35%	50%[2,3]
Inpatient physician services	30%	35%	50%
Outpatient visits for severe mental health conditions	$35	35%	50%
Outpatient visits for non-severe mental health conditions (up to 20 visits per calendar year combined with chemical dependency visits)[8]	30%	35%	Not covered
Chemical dependency services[7] (substance abuse)			
Inpatient hospital facility services for medical acute detoxification	30%	35%	50%[2,3]
Inpatient physician services for medical acute detoxification	30%	35%	50%
Outpatient visits (up to 20 visits per calendar year combined with non-severe mental health visits)[8]	30%	35%	Not covered

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Covered services	Member copayments		
Subject to the plan deductible, unless noted.	With preferred providers,[1] you pay		With non-preferred providers,[1] you pay
	PPO 5000	PPO 5500	
Home health services (up to 90 pre-authorized visits per calendar year)	30%	35%	Not covered
Other			
Pregnancy and maternity care			
Outpatient prenatal and postnatal care	30%	35%	50%
Delivery and all necessary inpatient hospital services	30%	35%	50%[2,3]
Family planning			
Consultations, tubal ligation, vasectomy, elective abortion	30%	35%	Not covered
Rehabilitation services			
Provided in the office of a physician or physical therapist	30%	35%	50%
Chiropractic services	Not covered	Not covered	Not covered
Out-of-state services (full plan benefits covered nationwide with the BlueCard Program)	30% with BlueCard participating providers	35% with BlueCard participating providers	50% with all other providers

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

- Plan benefits provided before you need to meet the medical deductible.

1 Member is responsible for copayment/coinsurance in addition to any charges above allowable amounts. The coinsurance/copayment indicated is a portion of the allowable 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/coinsurance 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 it 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 Participating ASCs may not be available in all areas. Regardless of their availability, you can obtain outpatient surgery services from a hospital, or an ASC affiliated with a hospital with payment according to your health plan's hospital services benefits. Blue Shield's payment is limited to $150 per day. Members are responsible for all charges that exceed $150 per day.

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, 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 EOC/Policy for further benefit detail.

6 If a member requests a brand-name prescription 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. Prescription coverage differs for home self-injectables. See the EOC/Policy for details.

7 Blue Shield has contracted with a specialized health care 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 (not MHSA) providers.

8 For MHSA participating providers initial visit treated as if the condition was a severe mental illness or Serious Emotional Disturbance of a Child. For MHSA non-participating providers, initial visit treated as a MHSA participating provider. See EOC for details.