Premier PPO 45†

Benefit Summary (For groups 2 to 50)
(Uniform Health Plan Benefits and Coverage Matrix)

Blue Shield of California
Life & Health Insurance Company

Effective January 1, 2012

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE *CERTIFICATE OF INSURANCE* AND GROUP POLICY SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

DEDUCTIBLE[1]	**Preferred Providers**[3]	**Non-Preferred Providers**[3]
Calendar Year Medical Deductible[1] (All providers combined)	$1,000 per Individual/ $2,000 per Family	$1,500 per Individual/ $3,000 per Family
Calendar Year Brand Name Drug Deductible	None	
Calendar Year Copayment Maximum[1] (Copayments for Preferred Providers accrue to both Preferred and Non-Preferred Provider Calendar Year Copayment Maximum amounts.)	$5,000 per Individual /$10,000 per Family	$7,000 per Individual /$14,000 per Family
LIFETIME BENEFIT MAXIMUM	None	

Covered Services	**Member Copayment**	
PROFESSIONAL SERVICES		
Professional (Physician) Benefits		
• Physician and specialist office visits	$45 per visit (Not subject to the Calendar Year Medical Deductible)	50%[1]
• Other outpatient X-ray, pathology and laboratory (Diagnostic testing by providers other than outpatient laboratory, pathology, and imaging departments of hospitals/facilities)[16]	45%	50%[1]
• CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine (prior authorization is required)[16]	45%	50%[1]
Allergy Testing and Treatment Benefits		
• Office visits (includes visits for allergy serum injections)	45%	50%
Preventive Health Benefits		
• Preventive Health Services (see the description of Preventive Health Services in the definitions section of the *Certificate of Insurance* for more information)	No charge[2] (Not subject to the Calendar Year Medical Deductible)	Not covered
OUTPATIENT SERVICES		
Hospital Benefits (Facility Services)		
• Outpatient surgery performed at an Ambulatory Surgery Center[4]	35%	50%[5]
• Outpatient surgery in a hospital	45%	50%[5]
• Outpatient Services for treatment of illness or injury and necessary supplies (Except as described under "Rehabilitation benefits")	45%	50%[1,5]
• Bariatric Surgery (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only)[6]	45%	50%[5]
• CT scans, MRIs, MRAs, PET scans, and cardiac diagnostic procedures utilizing nuclear medicine performed in a hospital (prior authorization is required)[16]	$100 per visit + 45%	50%[1,5]
• Other outpatient X-ray, pathology and laboratory performed in a hospital[16]	45%	50%[1,5]

Covered Services	Member Copayment	
HOSPITALIZATION SERVICES		
Hospital Benefits (Facility Services)		
• Inpatient Physician Services	45%	50%
• Inpatient Non-emergency Facility Services (Semi-private room and board, and medically necessary Services and supplies, including Subacute Care)	45%	50%[5]
• Bariatric Surgery (prior authorization required by the Plan; medically necessary surgery for weight loss, for morbid obesity only)[6]	45%	50%[5]
Skilled Nursing Facility Benefits[7]		
(Combined maximum of up to 100 prior authorized days per Calendar Year; semi-private accommodations)		
• Services by a free-standing Skilled Nursing Facility	45%	45%
• Skilled Nursing Unit of a Hospital	45%	50%[5]
EMERGENCY HEALTH COVERAGE		
• Emergency room Services not resulting in admission (Copayment does not apply if the member is directly admitted to the hospital for inpatient services)	$100 per visit[1]+ 45%	$100 per visit[1]+ 45%
• Emergency room Services resulting in admission (when the member is admitted directly from the ER)	45%	45%
• Emergency room Physician Services	45%	45%
AMBULANCE SERVICES		
• Emergency or authorized transport (surface or air)	45%	45%
PRESCRIPTION DRUG COVERAGE[1, 8, 9, 15]	**Participating Pharmacy**	**Non-Participating Pharmacy**
Retail Prescriptions (up to a 30-day supply)		
• Formulary Generic Drugs	$10 per prescription	Not covered
• Formulary Brand Name Drugs	$30 per prescription	Not covered
• Non-Formulary Brand Name Drugs	$50 per prescription	Not covered
Mail Service Prescriptions (up to a 90-day supply)		
• Formulary Generic Drugs	$20 per prescription	Not covered
• Formulary Brand Name Drugs	$60 per prescription	Not covered
• Non-Formulary Brand Name Drugs	$100 per prescription	Not covered
Specialty Pharmacies (up to a 30-day supply)		
• Specialty Drugs (May require prior authorization from Blue Shield Life Pharmacy Services. Specialty drugs are covered only when dispensed by select participating pharmacies in the Specialty Pharmacy Network. Drugs from non-participating pharmacies are not covered except in emergency and urgent situations. Mail service prescriptions are not covered. Member pays up to $100 copayment maximum per prescription)	30% per prescription	Not covered
PROSTHETICS/ORTHOTICS	**Preferred Providers**[3]	**Non-Preferred Providers**[3]
• Prosthetic equipment and devices (Separate office visit copay may apply)	45%	Not covered
• Orthotic equipment and devices (Separate office visit copay may apply)	45%	Not covered
DURABLE MEDICAL EQUIPMENT		
• Durable Medical Equipment	50%	Not covered

Covered Services	Member Copayment	
MENTAL HEALTH SERVICES (PSYCHIATRIC)[10]	**MHSA Participating Providers**[3]	**MHSA Non-Participating Providers**[3]
• Inpatient Hospital Services	45%	50%[5]
• Outpatient visits for severe mental health conditions	$45 per visit (Not subject to the Calendar Year Medical Deductible)	50%[1]
• Outpatient visits for non-severe mental health conditions (up to 20 visits per Calendar Year combined with outpatient chemical dependency visits)[11]	50%[1]	Not covered
CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)[10]**, PLEASE SEE FOOTNOTE 14**		
• Inpatient Hospital Services for medical acute detoxification	45%	50%[5]
• Outpatient visits (up to 20 visits per Calendar Year combined with outpatient non-severe mental health visits)[11]	50%[1]	Not covered
HOME HEALTH SERVICES	**Preferred Providers**[3]	**Non-Preferred Providers**[3]
• Home health care agency Services (up to 100 prior authorized visits per Calendar Year)	45%	Not covered[12]
• Home infusion/home intravenous injectable therapy and infusion nursing visits provided by a Home Infusion Agency	45%	Not covered[12]
OTHER		
Hospice Program Benefits		
• Routine home care	No charge	Not covered[12]
• Inpatient Respite Care	No charge	Not covered[12]
• 24-hour Continuous Home Care	45%	Not covered[12]
• General Inpatient care	45%	Not covered[12]
Chiropractic Benefits[11]		
• Chiropractic Services (up to 12 visits per Calendar Year; visit limit combines Outpatient chiropractic, Physical, Occupational, Respiratory, and Speech Therapy Services)	45%	50%
Acupuncture Benefits[11]		
• Acupuncture (up to 20 visits per Calendar Year)	$25 per visit	$25 per visit
Rehabilitation Benefits		
• Office location (up to 12 visits per Calendar Year; visit limit combines Outpatient chiropractic, Physical, Occupational, Respiratory, and Speech Therapy Services)	45%	50%
Pregnancy and Maternity Care Benefits		
• Prenatal and postnatal Physician office visits (For inpatient hospital services, see "Hospitalization Services.")	45%	50%
Family Planning Benefits		
• Counseling and consulting	45% (Not subject to the Calendar Year Medical Deductible)	Not covered
• Elective abortion[13]	45%	Not covered
• Tubal ligation[13]	45%	Not covered
• Vasectomy[13]	45%	Not covered
Diabetes Care Benefits		
• Devices, equipment and non-testing supplies (for testing supplies, see Prescription Drug Coverage.)	50%	Not covered
• Diabetes self-management training (If billed by your provider, you will also be responsible for the office visit copayment)	$45 per visit	50%

Care Outside of Plan Service Area (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 Line	See Applicable Benefit Line
• Outside of US: BlueCard Worldwide	See Applicable Benefit Line	See Applicable Benefit Line

Optional Benefits Optional dental, vision, substance abuse treatment and infertility benefits are available. If your employer purchased any of these benefits, a description of the benefit is provided separately.

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. Please refer to the *Certificate of Insurance* and the group policy for exact terms and conditions of coverage.

2 The preventive care and well-baby care office visit do not apply toward the plan deductible. Other covered non-preventive services received during or in connection with the office visit are subject to the plan deductible and the applicable copayment percentage

3 Member is responsible for copayment in addition to any charges above allowable amounts. The coinsurance indicated is a percentage of allowable amounts. Preferred providers accept Blue Shield of California Life & Health Insurance Company's (Blue Shield Life) 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 Life's allowable amount. Charges above the allowable amount do not count toward the Calendar Year deductible or copayment maximum.

4 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.

5 The maximum allowed charges for non-emergency hospital services received from a Non-Preferred Hospital are $600 per day. Members are responsible for 50% of this $600 per day, plus all charges in excess of $600. 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.

6 Bariatric surgery is covered when pre-authorized by Blue Shield Life. 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 of bariatric services from non-preferred providers. In addition, if prior authorized by Blue Shield Life, 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 *Certificate of Insurance* for further benefit details.

7 Services may require prior authorization by Blue Shield Life. When these services are prior authorized, members pay the preferred or participating provider level.

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.

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). Because this plan's prescription drug coverage is creditable, you do not have to enroll in a Medicare prescription drug plan 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 anytime after you were first eligible to enroll in a Medicare prescription drug plan, you could be subject to a late enrollment penalty in addition to your Part D premium.

9 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 Life for the brand-name drug and its generic drug equivalent, as well as the applicable generic drug copayment.

10 Mental health and chemical dependency services, other than medical acute detoxification, are accessed through Blue Shield Life's Mental Health Service Administrator (MHSA) – using Blue Shield Life MHSA participating and non-participating providers. Only Blue Shield MHSA contracted providers are administered by the Blue Shield Life MHSA. Behavioral health services rendered by non-participating providers are administered by Blue Shield Life. Services for medical acute detoxification are accessed through Blue Shield Life using Blue Shield Life's preferred providers or non-preferred providers. For a listing of severe mental illnesses, including serious emotional disturbances of a child, and other benefit details, please refer to the *Certificate of Insurance* or the group policy.

11 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.

12 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 benefits.

13 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.

14 **Optional inpatient substance abuse treatment benefits are available. If your employer purchased these benefits, a description of the benefit is attached hereto as "*Additional Substance Abuse Treatment Benefits*".**

15 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.

16 Participating non Hospital based ("freestanding") outpatient X-ray, pathology and laboratory facilities centers may not be available in all areas. Regardless of their availability, you can obtain outpatient X-ray, pathology and laboratory services from a hospital or an ambulatory surgery center affiliated with a hospital, with payment according to your health plan's hospital services benefits.

Plan designs may be modified to ensure compliance with state and federal requirements

†Pending regulatory approval