Shield Savings℠ 2250/4500

Benefit Summary (For groups 2 to 50)

(Uniform Health Plan Benefits and Coverage Matrix)

Blue Shield of California

Effective January 1, 2010

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE *EVIDENCE OF COVERAGE* AND THE PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

DEDUCTIBLES	**Preferred Providers**[1]	**Non-Preferred Providers**[1]
Calendar-Year Deductible (All providers combined) (Note: For family coverage, the full family deductible must be met before the enrollee or covered dependents can receive benefits for covered services.)	$2,250 per individual/$4,500 per family	
Calendar-Year Copayment Maximum (All providers combined; includes the plan deductible) (Note: For family coverage, the full family out-of-pocket maximum must be met before tl enrollee or covered dependents can receive 100% benefits for covered services.)	$4,500 per individual/$9,000 per family	
LIFETIME MAXIMUM	$6,000,000	

Covered Services ***Benefits are subject to the plan's calendar-year deductible unless otherwise noted.***	**Member Copayment**	
PROFESSIONAL SERVICES	**Preferred Providers**[1]	**Non-Preferred Providers**[1]
Physician services		
• Physician and specialist office visits	20%	50%
• Allergy testing or treatment	20%	50%
Laboratory, X-rays and diagnostics	20%	50%
Preventive care (Not subject to the Calendar-year deductible)		
• Annual routine physical exam office visit (One per calendar-year, age 3 or older), immunizations and vaccinations	$35/visit[2] (Not subject to the Calendar-Year Deductible)	Not covered
• Laboratory, including mammogram and Pap test screening or other FDA-approved cervical cancer screening tests	20% (Not subject to the Calendar-Year Deductible)	Not covered
OUTPATIENT SERVICES		
• Outpatient surgery performed in a participating ambulatory surge center (ASC)[3]	10%	50%[4]
• Outpatient surgery in hospital/facility	20%	50%[4]
• Outpatient treatment and necessary supplies	20%	50%[4]
• Bariatric surgery (Pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity)[5]	20%	50%[4]
HOSPITALIZATION SERVICES		
• Inpatient physician services (including pregnancy and maternity care)	20%	50%
• Semi-private room and board, medically necessary services and supplies	20%	50%[4]
• Bariatric surgery (Pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity)[5]	20%	50%[4]
Skilled nursing facility (SNF) services[6] (Combined maximum of up to 100 preauthorized days per calendar-year; semi-private accommodations)		
• Freestanding SNF	20%	20%
• Hospital SNF unit	20%	50%[4]

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Covered Services *Benefits are subject to the plan's calendar-year deductible unless otherwise noted.*	Member Copayment	
EMERGENCY HEALTH COVERAGE		
• Facility services (Not resulting in a direct admission)	$100/visit + 20%	$100/visit + 20%
• Facility services (Resulting in a direct admission)	20%	20%
• Emergency room physician visits	20%	20%
AMBULANCE SERVICES	20%	20%
PRESCRIPTION DRUG COVERAGE[7, 8, 9,] (Subject to plan deductible; includes oral contraceptives and diaphragms, and covered diabetic drugs and testing supplies)	**Participating Pharmacy**	**Non-Participating Pharmacy**
• Retail prescriptions (For up to a 30-day supply)		
o Generic drugs	o $10/prescription	o 50%/prescription
o Formulary brand-name drugs	o $30 or 30% of BSC contracted rate (whichever is greater)	o 50%/prescription
o Non-formulary brand-name drugs	o $50 or 50% of BSC contracted rate (whichever is greater)	o 50%/prescription
o Home self-administered injectable drugs (May require prior authorization from Blue Shield Pharmacy Services. Home self-administered injectable 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.)	o 30%/prescription	o Not covered
• Mail service prescriptions (For up to a 90-day supply)		
o Generic drugs	o $20/prescription	o Not covered
o Formulary brand-name drugs	o $60 or 30% of BSC contracted rate (whichever is greater)	o Not covered
o Non-formulary brand-name drugs	o $100 or 50% of BSC contracted rate (whichever is greater)	o Not covered
o Home self-administered injectable drugs	o Not covered	o Not covered
PROSTHETICS/ORTHOTICS	**Preferred Providers**[1]	**Non-Preferred Providers**[1]
• Prosthetic appliances and orthoses benefits (Equipment and devices only. Separate office visit copay may apply.)	20%	50%
DURABLE MEDICAL EQUIPMENT (Plan payment up to $2,000 maximum per person per calendar year)	50%	50%
MENTAL HEALTH SERVICES (PSYCHIATRIC)[10,]	**MHSA Participating Providers**[1]	**MHSA Non-Participating Providers**[1]
• Inpatient hospital facility services	20%	50%[4]
• Outpatient visits for severe mental health conditions	20%	50%
• Outpatient visits for non-severe mental health conditions (Up to 20 visits per calendar-year combined with outpatient chemical dependency visits)[11,]	50%	Not covered
CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)[10], **PLEASE SEE FOOTNOTE 13**		
• Inpatient services for medical acute detoxification	20%	50%[4]
• Outpatient visits (Up to 20 visits per calendar-year combined with outpatient non-severe mental health visits)[11,]	50%	Not covered

Covered Services *Benefits are subject to the plan's calendar-year deductible unless otherwise noted.*	Member Copayment	
HOME HEALTH SERVICES	**Preferred Providers[1]**	**Non-Preferred Providers[1]**
• Home health (Maximum of 100 prior authorized visits per calendar-year)	20%	Not covered[12]
• Home infusion care and home injectable treatment	20%	Not covered[12]
OTHER SERVICES		
Hospice		
• Routine home care	No charge	Not covered[12]
• Inpatient respite care	No charge	Not covered[12]
• 24 hour continuous home care	20%	Not covered[12]
• General inpatient care	20%	Not covered[12]
Pregnancy and maternity care		
• Prenatal and postnatal professional (physician) services (For all necessary inpatient hospital services, see "Hospitalization Services.")	20%	50%
Well-baby care (From birth through and including age 2; Not subject to the Calendar-year plan deductible)		
• Office visits and consultations	$35/visit[2]	Not covered
• Immunizations	20%	Not covered
• Laboratory screenings	20%	Not covered
Family planning		
• Family planning counseling	20%	Not covered
• Elective abortion[13], tubal ligation[13], vasectomy[13]	20%	Not covered
Rehabilitative therapy services		
• Outpatient visits	20%	50%
Alternative care		
• Chiropractic services provided by a chiropractor (Up to 20 visits per calendar-year)[11]	20%	50%
• Acupuncture services (Up to 20 visits per calendar-year and plan payment up to $25/visit)[11]	20%	20%
Diabetes care		
• Equipment, devices and non-testing supplies	50%	50%
• Self-management training and education (If billed by your provider, you will also be responsible for the office visit copayment)	20%	50%
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

Optional Benefits Optional dental, vision, or infertility benefit is 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 above 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 The preventive care and well-baby care office visit copayments 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 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 charges 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.

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 of 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 these services are prior authorized, members pay the preferred or participating provider level.

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 California for the brand-name drug and its generic drug equivalent, as well as the applicable generic drug copayment. The difference in cost that the member must pay is not applied to their 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. This plan's prescription drug coverage provides, on average, less coverage than the standard benefit set by the federal government for Medicare Part D (also called "non-creditable" coverage). It is important to know that you may only enroll in a Medicare Part D plan during specified times of the year, and if you do not enroll when first eligible you may be subject to payment of higher Medicare Part D premiums when you enroll at a later date. For more information about drug coverage, call the customer service number on your member ID card, Monday through Thursday, 8:00 am – 5:00 pm or Friday, 9:00 am - 5:00 pm. The hearing impaired may call the TTY number also listed on your member ID card.

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 Mental health and chemical dependency services, other than medical acute detoxification, are accessed through Blue -Shield's Mental Health Service Administrator (MHSA) - using Blue Shield MHSA participating and non-participating providers. Only Blue Shield MHSA contracted providers are administered by the Blue Shield MHSA. Behavioral health services rendered by non participating providers are administered by Blue Shield. Services for medical acute detoxification are accessed through Blue Shield using Blue Shield'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 Evidence of Coverage or plan contract.

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.*"**

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