Shield Spectrum PPO Savings Plans

NEW! PPO Savings Plan 1800/3600*

PPO Savings Plan 2400/4800

PPO Savings Plan 4000/8000*

*Underwritten by Blue Shield of California Life and Health Insurance Company. PPO Savings Plan 1800/3600 plan benefits are effective May 1, 2008.

Choose from a wide range of monthly rates, calendar-year deductibles, and benefits. In addition, these six PPO plans are HSA-compatible.

These six high-deductible health plans are compatible with a Health Savings Account (HSA), which offer you easy access to quality care and protection against major healthcare expenses.

Shield Spectrum PPO Savings Plan℠ advantages

- Choose from a wide range of deductibles.
- Your out-of-pocket maximum includes your plan deductible, so you'll pay only up to your plan's out-of-pocket maximum in a calendar year.
- Preventive care is provided for a fixed copayment before meeting any deductible.
- Get prescription drugs at our contracted rate at participating pharmacies.
- Convenient access to a mail service pharmacy benefit.
- No copay for covered prescription drugs once you meet the out-of-pocket maximum.
- The family deductible can be met by any family member or combination of family members. Once the family deductible is met, all remaining covered family members will have met their deductible.
- One of the state's largest PPO networks, so it's easy to find doctors and hospitals.
- Knowledgeable customer service representatives who can assist you and quickly answer your questions.

A Health Savings Account adds value to your plan

These plans can be paired with an HSA, which can offer qualified members* the opportunity to save on taxes.

What is an HSA?

HSAs are personal savings or investment accounts that you combine with a high-deductible health plan. You contribute pre-tax dollars, which you can use to pay for qualified medical expenses. Depending on which HSA you choose, you can decide how much to contribute, what investments to make, how much to use for medical expenses, and which medical expenses to pay from the account.

If you enroll any of our the PPO Savings Plans** and are qualified to open an HSA, you can use your tax-free HSA funds to pay for qualified medical expenses, even those not covered by your health plan. These include dentist visits, eye exams, acupuncture, and more. You can also accumulate tax-free funds for future healthcare funding needs such as long-term care.

If I don't want an HSA, can I still choose a Shield Spectrum PPO Savings Plan?

Absolutely! These plans are PPO health plans and HSA participation is optional. Regardless of your eligibility for an HSA, you can choose a Shield Spectrum PPO Savings Plan for affordable rates, extensive coverage, and nationwide access to providers.

* Please note that consumers who enroll in an HSA-eligible high-deductible health plan may be eligible to open an HSA, but should consult with a financial and/or tax adviser to confirm and determine if an HSA is a good financial fit for them. Blue Shield does not offer tax advice or HSAs. HSAs are offered through financial institutions.

** PPO Savings Plans 1800/3600, 2400/4800 and 4000/8000 are intended to qualify as a "high-deductible health plan" for the purposes of qualifying for a Health Savings Account (HSA), within the meaning of Section 223 of the Internal Revenue Code of 1986, as amended.

NOTICE: Blue Shield does not provide tax advice. If you intend to purchase this plan to use with an HSA for tax purposes, you should consult with your tax advisor about whether you are eligible and whether your HSA meets all legal requirements. Although we believe that these plans meet these legal requirements, the Internal Revenue Service has not ruled on whether the plans are qualified as high-deductible health plans. If you purchase one of these plans to obtain the income tax benefits associated with an HSA and the Internal Revenue Service rules that these plans do not qualify as high-deductible health plans, you may not be eligible for the income tax benefits associated with an HSA. In this instance, you may have adverse income tax consequences with respect to your HSA for all years in which you were not eligible. However, if there were such a ruling, or if government requirements for an HSA-eligible high-deductible health plan change, we intend to amend the Shield Spectrum PPO Savings Plans, if necessary, to meet the requirements of a qualified plan. The plan's monthly rates may also change as a result of a change in the plan(s).

Shield Spectrum PPO Savings Plans

HSA-compatible

PPO Savings Plan 1800/3600 plan benefits are effective May 1, 2008.

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

	1800/3600†	2400/4800	4000/8000†
Deductible*	$1,800 ($3,600 family)	$2,400 ($4,800 family)	$4,000 ($8,000 family)
Percentage copayment/ coinsurance	30% at preferred providers; 50% at non-preferred providers	30% at preferred providers 50% at non-preferred providers	No charge after deductible at preferred providers 50% with non-preferred providers
Calendar-year out-of-pocket maximum (includes the plan deductible)	Service with preferred providers: $5,600 individual/$11,200 family Services with all providers: $10,000 Individual/$20,000 family	Service with preferred providers: $4,000 individual/$7,200 family Services with all providers: $6,000 Individual/$10,000 family	Services with preferred providers: $4,000 ($8,000 family) Services with all providers: $5,000 ($10,000 family)
Lifetime maximum	$6,000,000	$6,000,000	$6,000,000

Please note: The deductibles and out-of-pocket maximum amounts may increase annually to reflect federal cost-of-living adjustment.

* For two-party/family coverage: Only after the family deductible is met will any individual be eligible for benefits. The family deductible adds together applicable expenses accrued by all covered family members.

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

● Plan benefits provided before you need to meet any 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
	1800/3600 and 2400/4800	4000/8000	
Professional services			
Office visits	$35	No charge after deductible	50%
Preventive care			
Annual routine physical exam, gynecological exam, well-baby care office visits (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 ●	$35 (no charge after deductible) ●	Not covered
Outpatient services			
Non-emergency services and procedures, outpatient surgery in a hospital	30%	No charge after deductible	50%[2]
Outpatient surgery performed in an ambulatory surgery center (ASC)[3]	30%	No charge after deductible	50%
Outpatient X-ray and laboratory	30%	No charge after deductible	50%
Hospitalization services			
Inpatient physician visits and consultations, surgeons and assistants, and anesthesiologists	30%	No charge after deductible	50%
Inpatient semiprivate room and board, services and supplies, and subacute care	30%	No charge after deductible	50%[2]
Bariatric surgery inpatient services (pre-authorization required: medically necessary surgery for weight loss, only for morbid obesity)[4]	30%	No charge after deductible	50%[2]

Shield Spectrum PPO Savings Plans

Covered services	Member copayments			
Subject to the plan deductible, unless noted.	**With preferred providers,[1] you pay**		**With non-preferred providers,[1] you pay**	
	1800/3600 and 2400/4800	**4000/8000**		
Emergency health coverage				
Emergency room services ($75 copayment/visit waived if the member is admitted directly to the hospital as an inpatient)	$75/visit + 30%	No charge after deductible	Covered at same level as preferred provider	
ER physician visits	30%	No charge after deductible	Covered at same level as preferred provider	
Ambulance services (surface or air)	30%	No charge after deductible	Covered at same level as preferred provider	
	At participating pharmacies (up to a 30-day supply)		**Mail service prescriptions** (up to a 60-day supply)	
Prescription drug coverage[5] (outpatient, subject to the plan medical deductible)	**1800/3600 and 2400/4800**	**4000/8000**	**1800/3600 and 2400/4800**	**4000/8000**
Generic formulary drugs	$10/prescription	No charge	$20/prescription	Covered at same level as participating pharmacies
Formulary brand-name drugs	$35/prescription	No charge	$70/prescription	
Non-formulary brand-name drugs	$50 or 50%/prescription, whichever is greater (maximum of $150/prescription)	No charge	$100 or 50%/prescription, whichever is greater (maximum of $300/prescription)	
	With preferred providers,[1] you pay		**With non-preferred providers,[1] you pay**	
	1800/3600 and 2400/4800	**4000/8000**		
Durable medical equipment[6]	30%	No charge after deductible	50%	
	With MHSA participating providers,[1,7] you pay		**With MHSA non-participating providers,[1,7] you pay**	
	1800/3600 and 2400/4800	**4000/8000**		
Mental health services				
Inpatient hospital facility services	30%	No charge after deductible	50%[2]	
Inpatient physician services	30%	No charge after deductible	50%	
Outpatient visits for severe mental health conditions	$35	No charge after deductible	50%	
Outpatient visits for non-severe mental health conditions (up to 20 visits per calendar year combined with chemical dependency visits)[9]	30%	No charge after deductible	Not covered	
Chemical dependency services (substance abuse)				
Inpatient hospital facility services for medical acute detoxification	30%	No charge after deductible	50%[2]	
Inpatient physician services for medical acute detoxification	30%	No charge after deductible	50%	
Outpatient visits (up to 20 visits per calendar year combined with non-severe mental health visits)[9]	30%	No charge after deductible	Not covered	
	With preferred providers,[1] you pay		**With non-preferred providers,[1] you pay**	
Home health services (up to 90 pre-authorized visits per calendar year)[9]	30%	No charge after deductible	Not covered	

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Covered services Subject to the plan deductible, unless noted.	Member copayments With preferred providers,[1] you pay		With non-preferred providers,[1] you pay
	1800/3600 and 2400/4800	4000/8000	
Other			
Pregnancy and maternity care			
Outpatient prenatal and postnatal care	30% (not covered for 1800/3600)	Not covered	50% (not covered for PPO Savings Plans 1800/3600 and 4000/8000)
Delivery and all necessary inpatient hospital services	30% (not covered for 1800/3600)	Not covered	50%[2] (not covered for PPO Savings Plans 1800/3600 and 4000/8000)
Family planning			
Consultations, tubal ligation, vasectomy, elective abortion	30%	No charge after deductible	Not covered
Rehabilitation services[8]			
Provided in the office of a physician or physical therapist	30%[8] (up to 20 visits per calendar year)	No charge after deductible	50%
Chiropractic services (up to 12 visits per calendar year – Blue Shield's payment is limited to $25/visit)	50%	No charge after deductible	Not covered
Out-of-state services (full plan benefits covered nationwide with the BlueCard Program)	30% with BlueCard participating providers	No charge after deductible with BlueCard participating providers	50% with all other providers

Please note: Benefits are subject to modification for subsequently enacted state or federal legislation. Shield Spectrum PPO Savings Plan 1800/3600 is subject to regulatory approval.

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

1 Member is responsible for fixed dollar or percentage copayment, in addition to any charges above allowable amounts. The copayment percentage indicated is a percentage of the allowed amounts. Preferred providers accept Blue Shield's allowable amount as payment in full for covered services. Non-preferred providers can charge more than the allowable amounts. When members use non-preferred providers, they must pay the applicable copayment plus any charges that exceed Blue Shield's allowable amount. Charges above the allowable amount do not count toward the plan deductible or the calendar year out-of-pocket maximum.

2 For non-emergency hospital services and supplies received from a non-preferred (non-network) hospital, Blue Shield's maximum payment is $300 per day. After the deductible is met, members are responsible for all charges that exceed $300 per day.

3 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. The maximum allowed charge for non-emergency surgery and services performed in a non-participating ASC is $300 per day. Members are responsible for 50% of this $300 per day, plus all charges in excess of $300.

4 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 details.

5 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, and it will not accrue to the copayment maximum. Prescription coverage differs for home self-injectables. Some prescriptions will require prior authorization to obtain coverage (see formulary). Use of ID card is required to obtain prescriptions from pharmacy or claim(s) will be denied. Please review the EOC/Policy before you purchase the plan.

6 For PPO Savings Plans 1800/3600 and 2400/4800, all covered orthotic equipment and services have a benefit maximum of $2,000 per member per calendar year, except those services covered under the prosthetic appliances, durable medical equipment, or the diabetes care benefit. For PPO Savings Plan 4000/8000, all covered durable medical equipment, prosthetic, and orthotic equipment and services have a combined benefit maximum of $2,000 per member per calendar year, except those services covered under the diabetes care benefit.

7 Blue Shield of California has 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 (not MHSA) providers.

8 Limit applies to visits to participating and non-participating providers combined for PPO Savings Plans 1800/3600 and 2400/4800. Additional visits will be authorized if Blue Shield determines that additional treatment is medically necessary.

9 For MHSA participating providers, initial visit treated as if the condition were a severe mental illness or serious emotional disturbance of a child. For MHSA non-participating providers, initial visit treated as an MHSA participating provider.