Vital Shield plans

NEW! Vital Shield 900

Vital Shield 2900

Underwritten by Blue Shield of California Life & Health Insurance Company. Pending regulatory approval. Vital Shield 900 plan benefits are effective May 1, 2008.

Protect yourself with our lowest-priced PPO plan for individuals.

Our Vital Shield℠ plans cover you with basic benefits and a low or moderate deductible choice in case of hospitalization, surgery, or other major medical events. This lower-priced PPO option covers two office visits and generic drugs, before you have to meet a deductible.

Vital Shield advantages

- Monthly rates starting at as low as $45.*
- Choice of low or moderate annual deductible ($900 or $2,900).
- You're covered at 100% after you meet the copayment maximum.
- Low copayments for generic prescription drugs at network pharmacies ($10).
- The calendar-year office visits, which can be used for preventive care, before you have to meet the deductible.
- One of California's largest PPO provider networks, so it's easy to find a doctor you want.
- Knowledgeable customer service representatives ready to help you and answer your questions.

Is a Vital Shield plan right for you?

Our lowest-priced PPO plans give you affordable coverage and protect you in case of major medical events, such as hospitalization. They are available for individuals only and offer basic benefits, so that you don't pay for services you don't expect to use, including maternity care or brand-name drug benefits.

* Individual ages 19-29, Tier 1, living in Contra Costa, California, July 2008. Rates may vary, and are for people in good health.

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

	Vital Shield 900	Vital Shield 2900
Deductible	$900	$2,900
Coinsurance	40% with preferred providers 50% with non-preferred providers	40% 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: $4,900 Services with all providers: $7,900	Services with preferred providers: $5,900 Services with all providers: $8,900
Lifetime maximum	$3,000,000	$3,000,000

● Plan benefits that are available before you need to meet the medical plan 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 coinsurance noted in the chart below when accessing preferred and non-preferred providers.

The benefits below apply to both the Vital Shield 900 and Vital Shield 2900 plans.

Covered services Subject to the plan deductible, unless noted.	Member copayments **With preferred providers,[1] you pay**	**With non-preferred providers,[1] you pay**
Professional services		
Office visits (first 2 visits/calendar year for any combination of preventive care and physician office visits – subsequent visits are subject to the copayment maximum)	$40[2,*] ●	No charge after copay maximum[2]
Preventive care		
Annual routine physical exam, well-baby care office visits, and gynecological exam office visit (first 2 visits/calendar year for any combination of preventive care and physician office visits – subsequent visits are subject to the copayment maximum)	$40[2,*] ●	Not covered
Annual 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	40% ●	Not covered
Outpatient services		
Non-emergency services and procedures, outpatient surgery in hospital	40%	50%[2,3]
Outpatient surgery performed in an ambulatory surgery center (ASC)[4]	40%	50%[2]
Outpatient or out-of-hospital X-ray and laboratory	No charge after copay maximum[2]	No charge after copay maximum[2]
Hospitalization services		
Inpatient physician visits and consultations, surgeons and assistants, and anesthesiologists	40%	50%
Inpatient semiprivate room and board, services and supplies, and subacute care	40%	50%[2,3]
Bariatric surgery inpatient services (pre-authorization required: medically necessary surgery for weight loss, only for morbid obesity)[5]	40%	50%[2,3]
Emergency health coverage		
Emergency room services ($100 copayment/visit waived if member is admitted directly to the hospital as an inpatient)	$100/visit + 40%	$100/visit + 40%
ER physician visits	40%	40%
Ambulance services (surface or air)	40%	40%
Prescription drug coverage[6] (outpatient)	**At participating pharmacies** (up to a 30-day supply)	**Mail service prescriptions** (up to a 60-day supply)
Generic formulary drugs	$10/prescription[2] ●	$20/prescription[2] ●
Formulary brand-name drugs	Not covered	Not covered
Non-formulary brand-name drugs	Not covered	Not covered
	With preferred providers,[1] you pay	**With non-preferred providers,[1] you pay**
Durable medical equipment	Not covered	Not covered

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Covered services	Member copayments	
Subject to the plan deductible unless noted.	**With MHSA participating providers,[1,7] you pay**	**With MHSA non-participating providers,[1,7] you pay**
Mental health services		
Inpatient hospital facility services	40%	50% [2,3]
Inpatient physician services	40%	50%
Outpatient visits for severe mental health conditions	40%	50% [2,3]
Outpatient visits for non-severe mental health conditions[8]	Not covered	Not covered
Chemical dependency services (substance abuse)		
Inpatient hospital facility services for medical acute detoxification	40%	50% [2,3]
Inpatient physician services for medical acute detoxification	40%	50%
Outpatient visits[8]	Not covered	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)	No charge after copay maximum[2]	Not covered
Other		
Pregnancy and maternity care		
Outpatient prenatal and postnatal care	Not covered	Not covered
Delivery and all necessary inpatient hospital services	Not covered	Not covered
Family planning		
Consultations, tubal ligation, vasectomy, elective abortion	No charge after copay maximum[2]	Not covered
Rehabilitation services		
Provided in the office of a physician or physical therapist	Not covered	Not covered
Out-of-state services (full plan benefits covered nationwide with the BlueCard® Program)	40% with BlueCard participating providers	50% with all other providers

Please note: Benefits are subject to modification for subsequently enacted state or federal legislation. Vital Shield 900 and 2900 are subject to regulatory approval.

* Member has two visits per calendar year before the calendar-year copayment/coinsurance maximum is met. After the two visits are used for any one purpose, the member pays 100% of the allowable amount for all of these services until the calendar-year copayment/coinsurance maximum is met, with no accrual to deductible or copayment/coinsurance maximum.

1 Member is responsible for copayment or coinsurance in addition to any charges above allowable amounts. The coinsurance indicated is a percentage 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 or coinsurance 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. They will continue to be charged once it is reached (except for office visits, X-ray and laboratory, home health services, and family planning). See Policy for details.

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. 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.

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 Policy for further benefit details.

6 Prescription coverage differs for home self injectables. Please review the Policy before you purchase the plan.

7 Blue Shield 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 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 a MHSA participating provider.