Shield Savings℠ 4800

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, 2011

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

DEDUCTIBLES	Preferred Providers[1]	Non-Preferred Providers[1]
Calendar-Year Deductible (Note: An individual within the family coverage may meet his/her deductible without having to meet the family aggregate. Deductible accumulates separately for preferred and non-preferred providers)	$4,800 per individual/$9,600 per family	$4,800 per individual/$9,600 per family
Calendar-Year Copayment Maximum (Includes the plan deductible) (Note: An individual within the family coverage may meet his/her out-of-pocket maximum without having to meet the family aggregate. Out-of-pocket maximum accumulates separately for preferred and non-preferred providers)	$5,900 per individual/$11,800 per family	$10,000 per individual/$20,000 per family
LIFETIME MAXIMUM	None	

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	0%	50%
• Allergy testing or treatment	0%	50%
Laboratory, X-rays and diagnostics	0%	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	No charge[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	No charge (Not subject to the Calendar-Year Deductible)	Not covered
OUTPATIENT SERVICES		
• Outpatient surgery in performed in a participating ambulatory surgery center (ASC)[3]	0%	50%[4]
• Outpatient surgery in hospital/facility	0%	50%[4]
• Outpatient treatment and necessary supplies	0%	50%[4]
• Bariatric surgery (Pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity)[5]	0%	50%[4]
HOSPITALIZATION SERVICES		
• Inpatient physician services (including pregnancy and maternity care)	0%	50%
• Semi-private room and board, medically necessary services and supplies	0%	50%[4]
• Bariatric surgery (Pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity)[5]	0%	50%[4]

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Covered Services *Benefits are subject to the plan's calendar-year deductible unless otherwise noted.*	Member Copayment	
	Preferred Providers[1]	**Non-Preferred Providers[1]**
Skilled nursing facility (SNF) services[6] (Combined maximum of up to 100 preauthorized days per calendar-year; semi-private accommodations)		
• Freestanding SNF	0%	0%
• Hospital SNF unit	0%	50%[4]
EMERGENCY HEALTH COVERAGE		
• Facility services (Not resulting in a direct admission)	$0/visit	$0/visit
• Facility services (Resulting in a direct admission)	0%	0%
• Emergency room physician visits	0%	0%
AMBULANCE SERVICES	0%	0%
PRESCRIPTION DRUG COVERAGE[7, 8, 9 ,15] (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)		
○ Generic drugs	○ $10/prescription	○ 50%/prescription
○ Formulary brand-name drugs	○ $30 or 30% of Blue Shield Life contracted rate (whichever is greater)/prescription	○ 50%/prescription
○ Non-formulary brand-name drugs	○ $50 or 50% of Blue Shield Life contracted rate (whichever is greater)/prescription	○ 50%/prescription
• Mail service prescriptions (For up to a 90-day supply)		
○ Generic drugs	○ $20/prescription	○ Not covered
○ Formulary brand-name drugs	○ $60 copay or 30% of Blue Shield Life contracted rate (whichever is greater)	○ Not covered
○ Non-formulary brand-name drugs	○ $100 copay or 50% of Blue Shield Life contracted rate (whichever is greater)	○ Not covered
• Specialty pharmacies		
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. Mail service prescriptions are not covered. Drugs from non-participating pharmacies are not covered except in emergency and urgent situations.)	○ 30%/prescription	○ Not covered
PROSTHETICS/ORTHOTICS	**Preferred Providers[1]**	**Non-Preferred Providers[1]**
• Prosthetic appliances and orthoses benefits (Equipment and devices only. Separate office visit copayment may apply.)	0%	Not covered
DURABLE MEDICAL EQUIPMENT	0%	Not covered

Covered Services	Member Copayment	
Benefits are subject to the plan's calendar-year deductible unless otherwise noted.		
MENTAL HEALTH SERVICES (PSYCHIATRIC)[10]	**MHSA Participating Providers[1]**	**MHSA Non Participating Providers[1]**
• Inpatient hospital facility services	0%	50%[4]
• Outpatient visits for severe mental health conditions	0%	50%
• Outpatient visits for non-severe mental health conditions (Up to 20 visits per calendar-year combined with outpatient chemical dependency visits)[11]	0%	Not covered
CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)[10], PLEASE SEE FOOTNOTE 14		
• Inpatient services for medical acute detoxification	0%	50%[4]
• Outpatient visits (Up to 20 visits per calendar-year combined with outpatient non-severe mental health visits)[11],	0%	Not covered
HOME HEALTH SERVICES	**Preferred Providers[1]**	**Non-Preferred Providers[1]**
• Home health (Maximum of 100 prior authorized visits per calendar-year)	0%	Not covered[12]
• Home infusion care and specialty drugs	0%	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	0%	Not covered[12]
• General inpatient care	0%	Not covered[12]
Pregnancy and maternity care		
• Prenatal and postnatal professional (physician) services (For all necessary inpatient hospital services, see "Hospitalization Services.")	0%	50%
Well-baby care (From birth through and including age 2; **Not subject to the Calendar-Year Deductible**)		
• Office visits and consultations	No charge[2] (Not subject to the Calendar-Year Deductible)	Not covered
• Immunizations	No charge (Not subject to the Calendar-Year Deductible)	Not covered
• Laboratory screenings	No charge (Not subject to the Calendar-Year Deductible)	Not covered
Family planning		
• Family planning counseling	0%	Not covered
• Elective abortion[13], tubal ligation[13], vasectomy[13]	0%	Not covered
Rehabilitative therapy services		
• Outpatient visits (Up to 12 visits per calendar-year for any combination of physical therapy, occupational therapy, speech therapy and respiratory therapy)	0%	50%
Alternative care		
• Chiropractic services provided by a chiropractor (Up to 20 visits per calendar-year)[11]	0%	50%
• Acupuncture services	Not covered	Not covered
Diabetes care		
• Equipment, devices and non-testing supplies	0%	Not covered

• Self-management training and education (If billed by your provider, you will also be responsible for the office visit copayment)	0%	50%

Covered Services *Benefits are subject to the plan's calendar-year deductible unless otherwise noted.*	Member Copayment	
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 Line	See Applicable Benefit Line

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 coinsurance indicated is a percentage of allowed 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 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 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 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.

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

7 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.

8 If the member requests a brand-name drug and a generic drug equivalent is available, the member is responsible for paying the difference between the cost to Blue Shield Life of the brand-name drug and its generic drug equivalent, as well as the applicable generic drug copayment. This difference in cost that the Subscriber must pay is not applied to the Calendar Year Deductible and is not included in the Calendar Year maximum out-of-pocket responsibility calculations.

9 For the Outpatient Drugs benefit, covered drugs obtained from Non-Participating Pharmacies will be subject to and accrue to the deductible and the copayment maximum for Preferred Providers.

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's MHSA participating and non-participating providers. Only Blue Shield Life 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 group policy.

11 All outpatient non-severe mental health, outpatient substance abuse, 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.

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

Shield Savings[SM] 4800 is pending regulatory approval