

Shield Savings 4000 (HSA)

HSA-compatible

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

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.

| | 4000/8000 |
|---|--|
| Deductible* | Services with preferred providers: \$4,000 (\$8,000 family) Services with non-preferred providers: \$5,000 (\$10,000 family) |
| Coinsurance | No charge after deductible with preferred providers 50% with non-preferred providers |
| Calendar-year out-of-pocket maximum (includes the plan deductible) | Services with preferred providers: \$4,000 (\$8,000 family) Services with non-preferred providers: \$15,000 (\$30,000 family) |
| Lifetime maximum | \$6,000,000 |

* For two-party/family coverage, individuals become eligible for benefits after the total of applicable expenses accrued by all covered family members meets the family deductible amount.

- Plan benefits provided before you need to meet the 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 |
|---|--|--|
| Professional services | | |
| Office visits | 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, and routine mammography when received as part of the preventive care exam) | \$0 • | Not covered |
| Outpatient services | | |
| Non-emergency services and procedures, outpatient surgery in a hospital | No charge after deductible | 50% ² |
| Outpatient surgery performed in an ambulatory surgery center (ASC) | No charge after deductible | 50% ³ |
| Outpatient X-ray and laboratory | No charge after deductible | 50% |
| Hospitalization services | | |
| Inpatient physician visits and consultations, surgeons and assistants, and anesthesiologists | No charge after deductible | 50% |
| Inpatient semiprivate room and board, services and supplies, and subacute care | No charge after deductible | 50% ² |
| Bariatric surgery inpatient services (pre-authorization required: medically necessary surgery for weight loss, only for morbid obesity) ⁴ | No charge after deductible | 50% ² |
| Emergency health coverage | | |
| Emergency room services | No charge after deductible | No charge after deductible |
| ER physician visits | No charge after deductible | No charge after deductible |

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Covered services

Member copayments

| Subject to the plan deductible, unless noted. | With preferred providers, ¹ you pay | With non-preferred providers, ¹ you pay |
|---|--|--|
| Ambulance services (surface or air) | No charge after deductible | No charge after deductible |
| Prescription drug coverage⁵ (outpatient; subject to the plan medical deductible) | At participating pharmacies (up to a 30-day supply) | Mail service prescriptions (up to a 60-day supply) |
| Generic formulary drugs | No charge after deductible | No charge after deductible |
| Formulary brand-name drugs | | |
| Non-formulary brand-name drugs | | |
| | With preferred providers,¹ you pay | With non-preferred providers,¹ you pay |
| Durable medical equipment⁶ | No charge after deductible | 50% |
| Mental health services⁷ | | |
| Inpatient hospital facility services | No charge after deductible | 50% ² |
| Inpatient physician services | No charge after deductible | 50% |
| Outpatient visits for severe mental health conditions | 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) ⁸ | No charge after deductible | Not covered |
| Chemical dependency services⁷ (substance abuse) | | |
| Inpatient hospital facility services for medical acute detoxification | No charge after deductible | 50% ² |
| Inpatient physician services for medical acute detoxification | No charge after deductible | 50% |
| Outpatient visits (up to 20 visits per calendar year combined with non-severe mental health visits) ⁸ | No charge after deductible | Not covered |
| Home health services (up to 90 pre-authorized visits per calendar year) | No charge after deductible | 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 deductible | Not covered |
| Rehabilitation services | | |
| Provided in the office of a physician or physical therapist (up to 20 visits per calendar year) | No charge after deductible | 50% |
| Chiropractic services (Blue Shield's payment is limited to \$25/visit) | No charge after deductible (up to 12 visits per calendar year) | Not covered |
| Out-of-state services (full plan benefits covered nationwide with the BlueCard Program) | No charge after deductible with BlueCard participating providers | 50% with all other providers |

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Please note: Benefits are subject to modification for subsequently enacted state or federal legislation.

- 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. Blue Shield's payment is limited to \$150 per day. Members are responsible for all charges that exceed \$150 per day.
- 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 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, 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. Refer to the Policy for further benefit details.
- 6 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 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.