

Shield Spectrum Savings plans:

- PPO Savings Plan 2400/4800
- PPO Savings Plan 4000/8000

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These 4 high-deductible health plans are compatible with a Health Savings Account (HSA). They offer easy access to quality care and protection against major healthcare expenses, with the potential for tax savings.

Shield Spectrum PPO Savings Plan advantages

- Choose from a 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.
- One of the state's largest PPO networks, so it's easy to find doctors and hospitals.
- Get prescription drugs at our contracted rate at participating pharmacies.
- Convenient access to a mail service pharmacy benefit.
- 100% coverage for prescription drugs once you meet the out-of-pocket maximum.
- Once the family deductible is met, all remaining covered family members will have access to benefits. The family deductible can be met by any family member or combination of family members.
- Knowledgeable customer service representatives who can assist you and quickly answer your questions.

Shield Spectrum PPO Savings Plans 2400 (individual)/4800 (family) and 4000 (individual)/8000 (family)[†]

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 Evidence of Coverage and Plan Contract/Policy for Individuals and Families should be consulted for a detailed description of coverage benefits and limitations.

	2400/4800	4000/8000
Deductible*	\$2,400 (\$4,800 family)	\$4,000 (\$8,000 family)
Percentage copayment/coinsurance	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)	Services with preferred and all providers: \$3,200 (\$5,800 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

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.

- Plan benefits provided before you need to meet any medical deductible are shown below with a colored 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
	2400/4800	4000/8000	
Professional services			
Office visits	30%	No charge after deductible	50%
Preventive care			
Annual routine physical exam, gynecological exam, well-baby care office visits	\$35 ●	\$35 (no charge after deductible) ●	Not covered
Annual Pap test or other approved cervical cancer screening tests and routine mammography, immunizations (with annual physical or in a separate office visit)	30% ●	30% (no charge after deductible) ●	Not covered
Outpatient services (the maximum allowed charges for non-emergency surgery and services performed in a non-participating ambulatory surgery center is \$300 per day—members are responsible for 50% of this \$300 per day, plus all charges in excess of \$300)			
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

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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
	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 and non-participating pharmacies (up to a 30-day supply)		Mail service prescriptions (up to a 60-day supply)
Prescription drug coverage (outpatient – subject to the plan medical deductible)	30%	No charge after deductible	Covered at same level as participating and non-participating pharmacies
	With preferred providers,¹ you pay		With non-preferred providers,¹ you pay
Durable medical equipment⁵	30%	No charge	50%
	With MHSA participating providers,^{1,6} you pay		With MHSA non-participating providers,^{1,6} you pay
Mental health services			
Inpatient hospital facility services	30%	No charge after deductible	50% ²
Inpatient physician services, outpatient visits for severe mental health conditions	30%	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)	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)	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)	30%	No charge after deductible	Not covered

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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
	2400/4800	4000/8000	
Other			
Pregnancy and maternity care			
Outpatient prenatal and postnatal care	30%	Not covered	50% (not covered for PPO Savings Plan 4000/8000)
Delivery and all necessary inpatient hospital services	30%	Not covered	50% ² (not covered for PPO Savings Plan 4000/8000)
Family planning			
Consultations, tubal ligation, vasectomy, elective abortion	30%	No charge after deductible	Not covered
Rehabilitation services			
Provided in the office of a physician or physical, occupational, or respiratory therapist	30%	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.

- 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 ambulatory surgery centers (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.
 - 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 For PPO Savings Plan 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.
 - 6 Blue Shield of California has contracted with a specialized health care 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.

Blue Shield Rating Regions

These rates are Blue Shield's "Tier 1" rates, and are offered to individuals and families in good health. Other rates may apply depending on underwriting determination. The rates are effective February 1, 2007. Rates are subject to change.

Blue Shield Rate Guarantee¹

Our rate guarantee program now offers new IFP members a rate guarantee for the first consecutive six (6) months of coverage from the member's original effective date (OED).

To find the rates that apply to you:

- 1 Locate your county of residence in one of the Blue Shield Rating Regions, then find the column for your region.
- 2 On the chart you'll see that rates are listed separately for single, party of two, family and YouthCareSM coverage. Locate the category that applies to you. *(If you have dependent children, you may want to consider covering them separately with YouthCare rates. This may cost less per month, especially if you are a single parent.)*
- 3 Under the type of coverage you've selected ("family," for example), find the age range of the person who will be the primary applicant. The rates that apply to you for each Blue Shield plan are in this row. *(If you're married, or applying with your domestic partner, use the younger spouse or partner as the primary applicant. It may lower your monthly dues!)*

Shield Spectrum PPOSM Savings Plans 2400 (4800 Family) and 4000 (8000 Family)² Rating Regions

Region 1: Alpine, Butte, Del Norte, Imperial, Inyo, Kern, Plumas, San Luis Obispo, Sonoma, Stanislaus, Trinity, Yolo and the following Santa Barbara ZIP codes: 93254, 93427, 93429, 93434, 93436-38, 93440-41, 93454-58, 93460, 93463-64

Region 2: Colusa, Kings, Madera, Mendocino, Merced, San Benito, San Joaquin, Siskiyou, Tulare

Region 3: Amador, Calaveras, Glenn, Modoc, Nevada, Placer, Sacramento, Shasta, Sierra, Tuolumne

Region 4: Alameda, Contra Costa, Santa Clara

Region 5: Marin, San Francisco, San Mateo

Region 6: El Dorado, Fresno, Humboldt, Lake, Lassen, Mariposa, Mono, Monterey, Napa, Santa Cruz, Solano, Sutter, Tehama, Yuba

Region 7: San Bernardino, San Diego, Santa Barbara except the ZIP codes listed in Rating Region 1

Region 8: Orange, Riverside, Ventura and the following Los Angeles ZIP codes: 91023, 91301, 91310, 91321-22, 91350-51, 91354-55, 91376-77, 91380-87, 91390, 91711, 91750, 91765-69, 91773, 91788-89, 91795, 91797, 91799, 93510, 93532, 93534-36, 93539, 93543-44, 93550-53, 93563, 93584, 93586, 93590-91, 93599

Region 9: Los Angeles except the ZIP codes listed in Rating Region 8

To learn about current rates for Guaranteed Issue plans, call **(800) 431-2809**.

Please Note: The rating regions are subject to change. Call Blue Shield to verify which rating region you are in.

¹ Does not apply to Guaranteed Issue Plans, rate actions based on age-band changes, rate actions based on a change in location to another rating region, or on plan transfers within the first six months of enrollment.

² Underwritten by Blue Shield of California Life & Health Insurance Company.

Shield Spectrum PPO Savings Plan 4000/8000

Age range	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9
Youth Care - Monthly dues for Blue Shield									
Under 1	\$ 127	\$ 127	\$ 127	\$ 121	\$ 140	\$ 138	\$ 111	\$ 122	\$ 130
1 to 18	43	46	46	45	52	52	46	50	51
Single - Monthly due for Blue Shield									
19 to 29	48	47	46	45	52	50	47	50	51
30 to 34	66	68	66	64	73	72	66	70	74
35 to 39	85	88	87	84	96	95	86	92	99
40 to 44	119	120	122	114	134	132	121	128	136
45 to 49	158	161	162	156	180	178	163	180	188
50 to 54	210	210	213	214	239	230	211	234	241
55 to 59	269	272	273	261	301	295	270	296	305
60 to 64	349	349	352	337	393	384	347	369	394
Party of two - Monthly dues for Blue Shield									
Under 30	92	94	94	90	104	101	93	97	105
30 to 34	135	136	136	132	151	147	136	143	153
35 to 39	176	177	179	168	197	194	175	187	198
40 to 44	239	242	241	231	269	264	240	253	274
45 to 49	311	313	316	300	353	347	315	351	369
50 to 54	404	409	411	415	464	451	409	460	474
55 to 59	523	528	532	507	588	579	523	580	595
60 to 64	678	685	687	656	763	751	684	719	770
Family - Monthly dues for Blue Shield									
Under 30	146	149	148	141	164	162	147	155	167
30 to 34	206	209	210	199	230	227	207	219	236
35 to 39	269	272	273	259	303	295	269	286	305
40 to 44	341	345	347	330	386	377	344	362	392
45 to 49	415	419	421	401	469	458	421	473	493
50 to 54	490	496	497	502	564	542	492	556	574
55 to 59	586	594	594	566	661	647	591	657	670
60 to 64	732	740	743	710	826	809	737	777	882

Shield Spectrum PPO Savings Plan 2400/4800

Age range	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9
Youth Care - Monthly dues for Blue Shield									
Under 1	\$ 153	\$ 160	\$ 160	\$ 159	\$ 179	\$ 175	\$ 141	\$ 159	\$ 165
1 to 18	54	58	59	60	67	65	57	64	66
Single - Monthly due for Blue Shield									
19 to 29	84	91	89	89	101	97	90	96	101
30 to 34	114	122	122	120	133	132	120	132	137
35 to 39	124	134	133	133	150	147	133	145	152
40 to 44	159	169	170	167	188	184	169	185	192
45 to 49	192	204	205	203	227	223	203	221	232
50 to 54	253	266	269	266	300	292	268	290	301
55 to 59	326	344	345	341	382	374	343	372	389
60 to 64	422	443	446	441	496	488	443	482	505
Party of two - Monthly dues for Blue Shield									
Under 30	166	174	176	174	197	191	175	189	199
30 to 34	224	237	236	235	265	257	237	257	270
35 to 39	247	260	262	257	291	286	259	283	295
40 to 44	312	329	331	326	368	362	329	356	375
45 to 49	378	397	400	393	447	437	398	432	454
50 to 54	490	519	522	515	579	569	518	564	592
55 to 59	634	668	673	662	747	735	664	723	758
60 to 64	823	866	871	858	967	949	865	938	982
Family - Monthly dues for Blue Shield									
Under 30	273	289	290	285	321	316	288	312	326
30 to 34	349	369	368	362	410	402	366	397	417
35 to 39	383	403	406	400	451	440	402	439	457
40 to 44	449	472	476	469	529	516	472	511	537
45 to 49	503	531	532	524	592	580	529	574	602
50 to 54	595	627	629	620	700	684	624	679	711
55 to 59	711	751	751	741	838	820	749	813	852
60 to 64	888	938	942	929	1047	1025	936	1014	1062