

# Vital Shield plans

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

Vital Shield 900

Vital Shield 2900

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

## Is a Vital Shield plan right for you?

Vital Shield<sup>SM</sup> plans cover you with basic benefits and a low or moderate deductible in case of hospitalization, surgery, or other major medical events. Even before you have to meet the deductible, these lower-priced PPO options cover preventive care, one office visit, and generic prescription drugs. They are available for individuals only and offer many popular benefits, so you don't pay for services you don't expect to use, such as maternity care or brand-name prescription drug benefits.

## Vital Shield advantages

Choice of low or moderate annual deductible (\$900 or \$2,900).

Most in-network benefits are covered at 100% after you meet the copayment maximum.

Preventive care at no additional cost.

Low copayments for generic prescription drugs at network pharmacies (\$10).

One office visit each calendar year before you have to meet the deductible.

X-ray and laboratory outpatient services are \$0 with preferred providers once you meet the plan's copayment maximum.

Questions? Visit [www.Medicoverage.com](http://www.Medicoverage.com) or call (800) 930-7956

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

	Vital Shield 900	Vital Shield 2900
<b>Deductible</b>	\$900	\$2,900
<b>Coinsurance</b>	40% with preferred providers 50% with non-preferred providers	40% with preferred providers 50% with non-preferred providers
<b>Calendar-year copayment/coinsurance maximum</b> (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
<b>Lifetime maximum</b>	No limit	No limit

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

- 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.

### Covered services

Subject to the plan deductible, unless noted.

### Member copayments

	With preferred providers, <sup>1</sup> you pay	With non-preferred providers, <sup>1</sup> you pay
<b>Professional services</b>		
Office visits (one visit per calendar year – subsequent visits are subject to the copayment maximum)	\$40 <sup>3,*</sup> ●	\$0 after copay maximum <sup>3</sup>
<b>Preventive care</b>		
Annual routine physical exam, well-baby care office visits, and gynecological exam office visit	\$0 ●	Not covered
Annual Pap test or other approved cervical cancer screening tests, routine mammography, and immunizations when received as part of the preventive care exam	\$0 ●	Not covered
<b>Outpatient services</b>		
Non-emergency services and procedures, outpatient surgery in hospital	40%	50% <sup>2,4</sup>
Outpatient surgery performed in an ambulatory surgery center (ASC)	40%	50% <sup>2,5</sup>
Outpatient or out-of-hospital X-ray and laboratory	\$0 after copay maximum <sup>3</sup>	\$0 after copay maximum <sup>3</sup>
<b>Hospitalization services</b>		
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% <sup>2,4</sup>
Bariatric surgery inpatient services (pre-authorization required: medically necessary surgery for weight loss, only for morbid obesity) <sup>6</sup>	40%	50% <sup>2,4</sup>
<b>Emergency health coverage</b>		
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%
<b>Ambulance services</b> (surface or air)		
	40%	40%
<b>Prescription drug coverage<sup>7</sup></b> (outpatient)		
Generic formulary drugs	At participating pharmacies (up to a 30-day supply) \$10/prescription <sup>2</sup> ●	Mail service prescriptions (up to a 60-day supply) \$20/prescription <sup>2</sup> ●
Formulary brand-name drugs	Not covered	Not covered
Non-formulary brand-name drugs	Not covered	Not covered

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Covered services	Member copayments	
	With preferred providers, <sup>1</sup> you pay	With non-preferred providers, <sup>1</sup> you pay
Subject to the plan deductible unless noted.		
<b>Durable medical equipment</b>	Not covered	Not covered
<b>Mental health services<sup>8</sup></b>		
Inpatient hospital facility services	40%	50% up to \$500 per day <sup>2,4</sup>
Inpatient physician services	40%	50%
Outpatient visits for severe mental health conditions	40%	50% up to \$500 per day <sup>2,4</sup>
Outpatient visits for non-severe mental health conditions <sup>9</sup>	Not covered	Not covered
<b>Chemical dependency services<sup>8</sup></b> (substance abuse)		
Inpatient hospital facility services for medical acute detoxification	40%	50% <sup>2,4</sup>
Inpatient physician services for medical acute detoxification	40%	50%
Outpatient visits <sup>9</sup>	Not covered	Not covered
<b>Home health services</b> (up to 90 pre-authorized visits per calendar year)	\$0 after copay maximum <sup>3</sup>	Not covered
<b>Other</b>		
<b>Pregnancy and maternity care</b>		
Outpatient prenatal and postnatal care	Not covered	Not covered
Delivery and all necessary inpatient hospital services	Not covered	Not covered
<b>Family planning</b>		
Consultations, tubal ligation, vasectomy, elective abortion	\$0 after copay maximum <sup>3</sup>	Not covered
<b>Rehabilitation services</b>		
Provided in the office of a physician or physical therapist	Not covered	Not covered
<b>Chiropractic services</b>		
	Not covered	Not covered
<b>Out-of-state services</b> (full plan benefits covered nationwide with the BlueCard <sup>®</sup> Program)	40% 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.
  - \* Member has one visit per calendar year before the calendar year copayment/coinsurance maximum is met. After the one visit is used, 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. Subsequent visits are \$0 after the copayment/coinsurance maximum is reached.
- 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 the copayment/coinsurance maximum is reached. See Policy for details.
  - 3 These copayments do not count toward the copayment/coinsurance maximum, but will not be charged once the copayment/coinsurance maximum is reached. See Policy for details.
  - 4 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.
  - 5 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.
  - 6 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. See Policy for details.
  - 7 Vital Shield plans do not cover brand-name prescription drugs with the exception of covered drugs and supplies for diabetes. Brand and generic diabetes medications/supplies are covered, and may be subject to Prior Authorization for medical necessity. Prescription coverage differs for home self-injectables. See Policy for details.
  - 8 Blue Shield 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.
  - 9 For MHSA participating providers initial visit treated as if the condition was a severe mental illness or serious emotional disturbance of a child. For MHSA non-participating providers initial visit treated as an MHSA participating provider.

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