

Bronze Plan - Blue Shield PPO

Plan Premiums	Coverage Type	2014-15 Bi-Weekly Rates
	Employee Only	\$146.02
	Employee + 1	\$290.04
	Employee + 2	\$409.57

Please note: This chart only highlights benefits. The Evidence of Coverage (EOC) and the official plan document contain comprehensive benefit details and govern your rights and benefits. If any discrepancy exists between this Chart and the official plan document, the official plan document will prevail.

	In-Network	Out-Of-Network
Providers, Deductibles, Maximums, PreExisting Conditions		
Choice of physician and other providers	Shield PPO Network (includes Blue Card Program access)	Out-Of-Network
Calendar year Deductible combined PPO/OON	\$4,000 per individual \$8,000 per family	
Hospital or Ambulatory Surgical Center deductible	None	
Lifetime benefits maximum	None	
Out-of-Pocket annual maximum	\$5,500 each member \$11,000 family maximum (Some benefits excluded from the OoP maximum, refer to EOC for details)	\$10,000 each member \$20,000 family maximum (Some benefits excluded from the OoP maximum, refer to EOC for details)
Preexisting condition	Fully covered	
Office/Outpatient Care		
Office visits	You pay 20% after CY deductible	You pay 50% after CY deductible
Preventive Health Benefits	No charge [CY ded. Waived]	Not covered
Hearing screenings	No charge [CY ded. Waived]	You pay 50% after CY deductible
Immunizations	No charge [CY ded. Waived]	You pay 50% after CY deductible
Family planning		
Infertility services	Not covered	Not covered
Tubal ligation	No charge [CY ded. Waived]	Not covered
Vasectomy	You pay 20% after CY deductible	Not covered
Specialists	You pay 20% after CY deductible	You pay 50% after CY deductible
Well baby/Well child care	You pay 20% after CY deductible	You pay 50% after CY deductible
Well woman exam (annual)	No charge [CY ded. Waived]	You pay 50% after CY deductible
Emergency Medical Care		
Ambulance	You pay 20% after CY deductible	You pay 20% after CY deductible

Bronze Plan - Blue Shield PPO

Plan Premiums	Coverage Type	2014-15 Bi-Weekly Rates
	Employee Only	\$146.02
	Employee + 1	\$290.04
	Employee + 2	\$409.57

Please note: This chart only highlights benefits. The Evidence of Coverage (EOC) and the official plan document contain comprehensive benefit details and govern your rights and benefits. If any discrepancy exists between this Chart and the official plan document, the official plan document will prevail.

	In-Network	Out-Of-Network
Emergency room	\$100 per visit + 20% after CY deductible (\$100 waived if admitted) ER Physician Services: You pay 20% after CY deductible	\$100 per visit + 20% after CY deductible (\$100 waived if admitted) ER Physician Services: You pay 20% after CY deductible
Urgent care	You pay 20% after CY deductible	You pay 50% after CY deductible
Diagnostic Services		
Laboratory and Pathology Tests	You pay 20% after CY deductible	You pay 50% after CY deductible
Diagnostic Tests and X-Ray	You pay 20% after CY deductible	You pay 50% after CY deductible
Diabetes Care		
Covered Diabetic drugs and testing supplies	See 'Prescription Drugs'	
Diabetes Self Management Training & Education	You pay 20% after CY deductible	You pay 50% after CY deductible
Devices, Equipment, and Non-Testing Supplies	You pay 20% after CY deductible	You pay 50% after CY deductible
Maternity care		
Prenatal and Postnatal office visits	You pay 20% after CY deductible	You pay 50% after CY deductible
Delivery	You pay 20% after CY deductible	You pay 50% after CY deductible plus any charges over \$600/day
New Born Care	Newborn covered 30 days; must enroll through County within 60 days	Newborn covered 30 days; must enroll through County within 60 days
Hospital Services		
Hospital care (Physician and Facility charges)	You pay 20% after CY deductible	You pay 50% after CY deductible plus any charges over \$600/day
Surgical Services		
Hospital - In Patient Surgical Services	Facility: You pay 20% after CY deductible Physician: You pay 20% after CY deductible	Facility: You pay 50% after CY deductible plus any charges over \$600/day Physician: You pay 50% after CY deductible

Bronze Plan - Blue Shield PPO

Plan Premiums	Coverage Type	2014-15 Bi-Weekly Rates
	Employee Only	\$146.02
	Employee + 1	\$290.04
	Employee + 2	\$409.57

Please note: This chart only highlights benefits. The Evidence of Coverage (EOC) and the official plan document contain comprehensive benefit details and govern your rights and benefits. If any discrepancy exists between this Chart and the official plan document, the official plan document will prevail.

	In-Network	Out-Of-Network
Outpatient/Ambulatory Surgery Center	Facility: You pay 20% after CY deductible Physician: You pay 20% after CY deductible	Facility: You pay 50% after CY deductible plus all charges over \$350/day Physician: You pay 50% after CY deductible
Alternatives to Hospital Care		
Home health services	You pay 20% after CY deductible (100 visits per calendar year combined PPO/OoN maximum)	If preauthorized you pay 20% after CY deductible
Hospice Respite Care Inpatient & outpatient	No charge [CY ded. Waived]	If preauthorized, no charge
Skilled nursing facilities	You pay 20% after CY deductible (100 visits per calendar year combined PPO/OoN maximum)	Freestanding: SNF if preauthorized You pay 20% after deductible 50% for OON skilled nursing unit of a hospital
Mental Health Care and Substance Abuse Treatment		
	MHSA Participating Provider	MHSA Non-Participating Provider
Non-severe mental disorders	Inpatient: You pay 20% after CY deductible plus \$100 per admission Outpatient: You pay 20% after CY deductible	Inpatient: You pay 50% after CY deductible plus \$100 per admission and all charges over \$600/day Outpatient: You pay 50% after CY deductible
Severe mental disorders		
Substance abuse	MHSA Participating Provider	MHSA Non-Participating Provider
	Not covered	Not covered
Prescription Drugs		

Bronze Plan - Blue Shield PPO

Plan Premiums	Coverage Type	2014-15 Bi-Weekly Rates
	Employee Only	\$146.02
	Employee + 1	\$290.04
	Employee + 2	\$409.57

Please note: This chart only highlights benefits. The Evidence of Coverage (EOC) and the official plan document contain comprehensive benefit details and govern your rights and benefits. If any discrepancy exists between this Chart and the official plan document, the official plan document will prevail.

	In-Network	Out-Of-Network
Prescription drugs (per fill) Includes Diabetic drugs and testing supplies	<u>PARTICIPATING PHARMACY</u> Pharmacy: \$10 generic formulary \$25 brand formulary \$40 non-formulary Specialty Pharmacies: 30% up to \$200 OoP maximum per prescription (up to a 30-day supply) Mail Order is voluntary 90 day supply at discounted rate	<u>NON-PARTICIPATING PHARMACY</u> (Member pays 25% of billed amount plus copayment) Pharmacy: \$10 generic formulary, \$25 brand formulary, \$40 non-formulary Specialty Pharmacies: Not covered Mail Order not covered
	Pharmacy (retail and mail order) copays do not apply toward the out-of-pocket maximum.	
Other Services		
Allergy testing, treatment, and serum	You pay 20% after CY deductible	You pay 50% after CY deductible
Chiropractic care	You pay 20% after CY deductible	You pay 50% after CY deductible
	Up to 20 visits per calendar year combined PPO/OoN maximum	
Durable medical equipment	You pay 20% after CY deductible	You pay 50% after CY deductible
Home visits (Physician)	You pay 20% after CY deductible	If preauthorized, You pay 20% after CY deductible
Physical and Occupational Therapy	You pay 20% after CY deductible	You pay 50% after CY deductible
Speech Therapy	You pay 20% after CY deductible	You pay 20% after CY deductible
Vision (exam only)	Not covered	
Travel		
Network	Inside of US: Blue Card Program Outside of US: Blue Card World Wide Refer to your EOC	Inside of US: Blue Card Program Outside of US: Blue Card World Wide Refer to your EOC
Immunizations for purposes of Foreign Travel	You pay 20% after CY deductible	You pay 50% after CY deductible
Additional Travel Information	blueshieldca.com	blueshieldca.com