

Vital Shield Plus plans

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

Vital Shield Plus 900

Vital Shield Plus 900 Generic Rx

Vital Shield Plus plans provide you with the basics, and give you optional brand-name prescription drug coverage, for lower monthly rates.

Is a Vital Shield Plus plan right for you?

You want the same coverage as our Vital Shield plans, **plus** more covered office visits in a calendar year, **plus** a lower deductible option, **plus** brand or generic prescription drug options, **plus** lower office visit copayments. Vital ShieldSM Plus plans offer you and your family the vital health coverage you need to protect yourself against the high costs of hospitalization, surgery, and other major medical events. And with no maternity coverage and generic prescription drug coverage options, you aren't paying for services you don't expect to use.

Vital Shield Plus advantages

4 office visits each calendar year before you have to meet the deductible, so you will get the care you need in case of illness.

\$10 generic prescription drug coverage right away, before you have to meet a deductible, at network pharmacies.

Most benefits are covered at 100% after you meet the coinsurance maximum, so you're protected when you need it most.

Preventive care at no additional cost.

Outpatient X-ray and laboratory services accrue to the copayment maximum when using preferred providers, and are \$0 with preferred providers once you meet the plan's copayment maximum.

If you do not meet your annual deductible in a calendar year, you can "carry over" the amount accrued, from October to December of that year, and apply it towards your annual medical deductible for the following year.

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

	Vital Shield Plus 900 Vital Shield Plus 900 Generic Rx
Deductible*	Services with preferred providers: \$900 (\$1,800 family) Services with non-preferred providers: \$5,000 (\$10,000 family)
Coinsurance	40% with preferred providers 50% with non-preferred providers
Calendar-year copayment/ coinsurance maximum (includes the plan deductible – some services do not apply)	Services with preferred providers: \$3,900 (\$7,800 family) Services with non-preferred providers: \$15,000 (\$30,000 family)
Lifetime maximum	No limit

The benefits below apply to all Vital Shield Plus plans.

- Plan benefits provided before you need to meet the deductible are shown below with a dot. For all benefits without a colored 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 (first 4 visits per calendar year – subsequent visits are subject to the copayment maximum)	\$30 ^{3,*} ●	\$0 after copay maximum ³
Preventive care		
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
Outpatient services		
Non-emergency services and procedures, outpatient surgery in hospital	40%	50% ^{2,4}
Outpatient surgery performed in an ambulatory surgery center (ASC)	40%	50% ^{2,5}
Outpatient or out-of-hospital X-ray and laboratory	\$0 after copay maximum	\$0 after copay maximum ³

* If the annual plan deductible has not been met, any charges that accumulate towards the plan deductible in the last three months of the calendar year will be credited towards the plan deductible for the following calendar year. Benefits for covered brand-name prescription drugs are subject to a brand-name drug deductible per person. Vital Shield Plus 400, 900 and 2900 have a \$500 brand-name drug deductible. Vital Shield Plus 400, 900 and 2900 Generic Rx do not offer brand-name prescription drug coverage with the exception of covered drugs and supplies for diabetes, and are not subject to a brand-name drug deductible.

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Covered services Subject to the plan deductible unless noted.	Member copayments	
	With preferred providers, ¹ you pay	With non-preferred providers, ¹ you pay
Hospitalization services		
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% ^{2,4}
Bariatric surgery inpatient services (pre-authorization required: medically necessary surgery for weight loss, only for morbid obesity) ⁶	40%	50% ^{2,4}
Emergency health coverage		
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%
Ambulance services (surface or air)	40%	40%

	Vital Shield Plus 400, 900, and 2900	
Prescription drug coverage⁷ (outpatient)	At participating pharmacies (up to a 30-day supply)	Mail service prescriptions (up to a 60-day supply)
Generic formulary drugs	\$10/prescription ² ●	\$20/prescription ² ●
Formulary brand-name drugs	\$45/prescription ²	\$90/prescription ²
Non-formulary brand-name drugs	Not covered	Not covered
Brand-name drug deductible (brand-name drugs are subject to a brand-name drug deductible per person, per calendar year)	\$500	

Vital Shield Plus 400, 900 and 2900 Generic Rx do not cover brand-name 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. All other plan benefits are the same.

	With preferred providers, ¹ you pay	With non-preferred providers, ¹ you pay
Durable medical equipment	Not covered	Not covered
Mental health services⁸		
Inpatient hospital facility services	40%	50% up to \$500 per day ^{2,4}
Inpatient physician services	40%	50%
Outpatient visits for severe mental health conditions	40%	50% up to \$500 per day ^{2,4}
Outpatient visits for non-severe mental health conditions ⁹	Not covered	Not covered
Chemical dependency services⁸ (substance abuse)		
Inpatient hospital facility services for medical acute detoxification	40%	50% ^{2,4}
Inpatient physician services for medical acute detoxification	40%	50%
Outpatient visits ⁹	Not covered	Not covered
Home health services (up to 90 pre-authorized visits per calendar year)	\$0 after copay maximum ³	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
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	\$0 after copay maximum ³	Not covered
Rehabilitation services		
Provided in the office of a physician or physical therapist	Not covered	Not covered
Chiropractic services		
	Not covered	Not covered
Out-of-state services (full plan benefits covered nationwide with the BlueCard Program)	40% 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
- * Member has four visits per calendar year before the calendar year copayment/coinsurance maximum is met. After the four visits are 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 has four visits per calendar year before the calendar year copayment/coinsurance maximum is met. After the four visits are 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.
- 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 If a member requests a brand-name prescription drug or the physician indicates "dispense as written" (DAW) for a prescription, when an equivalent generic drug is available, and the brand-name drug deductible has been satisfied, the member pays the generic copayment plus the cost difference between the brand and generic drug. 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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