

Schools Insurance Group
 Shield Spectrum PPOSM Savings Plus 2250
 Benefit Summary (For groups of 51 and above)
 (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, DISCLOSURE FORM AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Blue Shield of California

Highlights: \$2,250 individual coverage deductible
 or \$4,500 family coverage deductible

Effective July 1, 2007

DEDUCTIBLES

Calendar-year deductible (All providers combined)

(Note: For family coverage, the full family deductible must be met before the enrollee or covered dependents can receive benefits for covered services.)

Preferred Providers ¹	Non-Preferred Providers ¹
\$2,250 per individual/\$4,500 per family	

Calendar-year out-of-pocket maximum¹ (Includes the plan deductible)

(Note: For family coverage, the full family out-of-pocket maximum must be met before the enrollee or covered dependents can receive 100% benefits for covered services.)

\$3,000 per individual/\$5,500 per family

LIFETIME MAXIMUMS

\$6,000,000

Covered Services

Member Copayment

PROFESSIONAL SERVICES

Physician services

- Physician and specialist office visits
- Allergy testing or treatment

Preferred Providers ¹	Non-Preferred Providers ¹
20%	50%
20%	50%
20%	50%

Laboratory, X-rays and diagnostics

Preventive care (Not subject to the plan's calendar-year deductible)

- Annual physical exam office visit (One per calendar year, age 3 and older), immunizations and vaccinations
- Laboratory, including mammogram and Pap test screening or other FDA-approved cervical cancer screening tests

\$35 ²	Not covered
20% ²	Not covered

OUTPATIENT SERVICES

The maximum allowed charges for non-emergency surgery and services performed in a non-participating Ambulatory Surgery Center or outpatient unit of a non-preferred hospital is \$350 per day. Members are responsible for 50% percent of this \$350 per day, plus all charges in excess of \$350.

- Outpatient surgery performed in a Participating Ambulatory Surgery Center³ (ASC)
- Outpatient surgery in hospital/facility
- Outpatient treatment and necessary supplies

20%	50%
20%	50%
20%	50%

HOSPITALIZATION SERVICES

Inpatient services – non-emergency

- Inpatient physician services
- Semi-private room and board, medically necessary services and supplies
- Bariatric Surgery⁵ (pre-authorization required; medically necessary surgery for weight loss, for morbid obesity only)

20%	50%
20%	50% ⁴
20%	50% ⁴

Skilled nursing facility (SNF) services⁶

(Combined maximum of up to 100 preauthorized days per calendar year; semi-private accommodations)

- Freestanding SNF
- Hospital SNF unit

20%	20% with prior authorization ⁶
20%	50% ⁴
20%	20%

EMERGENCY HEALTH COVERAGE

(Members must meet an additional \$50 copayment per emergency room visit before benefits apply. This copayment is waived if the member is directly admitted to the hospital for inpatient services.)

AMBULANCE SERVICES

20%	20%
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PRESCRIPTION DRUG COVERAGE^{7, 8} (Subject to deductible; includes oral contraceptives and diaphragms)

- Retail pharmacy and mail service prescriptions

20%	20%
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PROSTHETICS/ORTHOTICS

20%	50%
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DURABLE MEDICAL EQUIPMENT

(Plan payment up to \$2,000 maximum per calendar year)

20%	50%
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MENTAL HEALTH SERVICES (PSYCHIATRIC)⁹	MHSA Participating Providers¹	MHSA Non-Participating Providers¹
<ul style="list-style-type: none"> Inpatient hospital facility services Outpatient visits for severe mental health conditions Outpatient visits for non-severe mental health conditions (Up to 20 visits per calendar year combined with outpatient chemical dependency visits)¹⁰ 	20% 20% 50%	50% ⁴ 50% Not covered
CHEMICAL DEPENDENCY SERVICES (SUBSTANCE ABUSE)⁹, Please see footnote 11		
<ul style="list-style-type: none"> Inpatient services for medical acute detoxification Outpatient visits (Up to 20 visits per calendar year combined with outpatient non-severe mental health visits)¹⁰ 	See "Hospitalization Services" 50%	See "Hospitalization Services" Not covered
HOME HEALTH SERVICES	Preferred Providers¹	Non-Preferred Providers¹
<ul style="list-style-type: none"> Home health and home infusion care, home injectable treatment (Up to 100 combined prior authorized visit maximum per calendar year)⁶ 	20%	20% with prior authorization ⁶
OTHER		
Hospice		
<ul style="list-style-type: none"> Routine home care and inpatient respite care 24 hour continuous home care and general inpatient care 	No charge 20%	No charge with prior authorization ⁶ 20% with prior authorization ⁶
Pregnancy and maternity care		
<ul style="list-style-type: none"> Prenatal and postnatal professional (physician) services (For all necessary inpatient hospital services, see "Hospitalization Services.") 	20%	50%
Well-baby care (From birth through and including age 2) (Not subject to the calendar-year deductible)		
<ul style="list-style-type: none"> Office visits and consultations Immunizations Laboratory screenings 	\$35 ² 20% ² 20% ²	Not covered Not covered Not covered
Family planning		
<ul style="list-style-type: none"> Family planning counseling Tubal ligation, elective abortion, vasectomy¹² 	20% 20%	Not covered Not covered
Rehabilitative therapy services		
<ul style="list-style-type: none"> Outpatient visits 	20%	50%
Acupuncture services (Up to 20 visits per calendar-year and plan payment up to \$25/visit) ¹⁰	20%	20%
Chiropractic services (Up to 20 visits per calendar year) ¹⁰		
<ul style="list-style-type: none"> Chiropractic services provided by a chiropractor 	20%	50%
Covered out-of-state services (Benefits provided through the BlueCard® Program) Benefits provided through BlueCard Program, for out-of-state emergency and non-emergency care, are provided at the preferred level of the local Blue Plan allowable amount when you use a Blue Cross/Blue Shield provider.	20%	50%
Diabetes care		
<ul style="list-style-type: none"> Equipment, devices and supplies Self-management training and education (If billed by your provider, you will also be responsible for the office visit copayment) 	20% 20%	50% 50%

Optional Benefits Optional dental, vision, inpatient substance abuse treatment or infertility benefits are available. If your employer purchased any of these benefits, a description of the benefit is provided separately.

- Member is responsible for copayment in addition to any charges above allowable amounts. The copayment percentage indicated is a percentage of allowed amounts. Preferred providers accept Blue Shield's allowable amount as full payment for covered services. Non-preferred providers can charge more than these amounts. When members use non-preferred providers, they must pay the applicable copayment plus any amount that exceeds Blue Shield's allowable amount. Charges in excess of the allowable amount do not count toward the calendar-year deductible or out-of-pocket maximum.
- The preventive care and well-baby care office visit are not subject to the plan deductible. Other covered services received during or in connection with the office visit are subject to the plan deductible and the applicable copayment percentage.
- Participating ambulatory surgery centers may not be available in all areas. Regardless of their availability, you can obtain outpatient surgery services from a hospital or an ambulatory surgery center affiliated with a hospital, with payment according to your health plan's hospital services benefits.
- The maximum allowed charge for non-emergency hospital services received from a non-preferred hospital is \$600 per day. Members are responsible for 50 percent of this \$600 per day, plus all charges in excess of \$600. Payments that exceed the allowed charge do not count toward the calendar-year out-of-pocket maximum, and continue to be charged after it is reached.
- 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 of California, 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 Evidence of Coverage for further benefit details.
- Services may require prior authorization by Blue Shield. When services are prior authorized, members pay 20 percent, the preferred provider amount.
- Includes coverage for medically necessary prescription drugs. Member presents Blue Shield ID card to participating Pharmacy and pays 100 percent of contract rate.
- This plan's prescription drug coverage is on average equivalent to or better than the standard benefit set by the federal government for Medicare Part D (also called "creditable" coverage). Since this plan's prescription drug coverage is creditable, you do not have to enroll in Medicare Part D while you maintain this coverage; however, you should be aware that if you have a subsequent break in this coverage of 63 days or more before enrolling in Medicare Part D you could be subject to payment of higher Medicare Part D premiums.

9 Mental health and chemical dependency services are accessed through the mental health services administrator (MHSA) - U.S. Behavioral Health Plan, California (USBHPC) - using MHSA participating and non-participating providers. MHSA non-participating providers are not administered by USBHPC. Services for medical acute detoxification are accessed through Blue Shield using Blue Shield's preferred providers or non-preferred providers. For a listing of severe mental illnesses, including serious emotional disturbances of a child, and other benefit details, please refer to the Evidence of Coverage or plan contract.

10 All outpatient non-severe mental health, outpatient substance abuse and chiropractic visits accrue to the calendar-year visit maximum regardless of whether the plan deductible has been met.

11 Optional inpatient substance abuse treatment benefits are available. If your employer purchased these benefits, a description of the benefit is attached hereto as "Additional Substance Abuse Treatment Benefits."

12 Copayment shown is for physician's services. If the procedure is performed in a facility setting (hospital or outpatient surgery center), an additional facility copayment may apply.

Plan designs may be modified to ensure compliance with state and federal requirements