

PPO 3500 (HSA-Compatible) Plan

These amounts show your share of costs after deductibles

Benefit	In-Network	Out-of-Network	
Annual Deductible (Combined for medical benefits and prescription drugs)	Single member: \$3,500 Families: \$7,000 aggregate*		<p>* When one or more family members' eligible covered expenses (combined) meet the aggregate amount, the requirement is satisfied for all covered family members.</p> <p>¹ Excludes non-participating charges in excess of the Blue Cross negotiated fee and non-participating charges in excess of customary and reasonable fees for emergency care. Copays/coinsurance to participating and non-participating providers apply to out-of-pocket maximum except where specifically noted in the policy.</p> <p>² Additional \$500 admission charge at participating hospitals (no additional charge for preferred participating) is for inpatient stays or outpatient surgery or infusion therapy. The charge is not required for ambulatory surgical centers or medical emergencies.</p> <p>³ Additional \$100 copay applies for each emergency room visit. Waived if admitted as inpatient.</p> <p>⁴ Tests ordered by a physician are covered, including appropriate screening for breast, cervical and ovarian cancer.</p> <p>⁵ One HealthyCheck visit at a HealthyCheck Center only allowed for each 12-month period. HealthyCheck applies only to adults and children age 7 and above.</p> <p>⁶ Visits to participating and non-participating providers combined. Additional visits may be authorized.</p> <p>⁷ Non-Formulary Drugs: After deductible, you pay 50% for generic, 50% for brand-name if no generic is available, or generic copay plus the difference between brand-name and available generic equivalent.</p> <p>⁸ If a member selects a brand-name drug when a generic equivalent drug is available, even if the physician writes a "dispense as written" or "do not substitute" prescription, the member will be responsible for the generic copay plus the difference in cost between the brand-name drug and the generic equivalent drug.</p>
Lifetime Maximum	\$5,000,000 per member		
Annual Out-of-Pocket Maximum¹ Participating and non-participating provider covered services apply (Combined for medical benefits and prescription drugs)	Single member: \$5,000 Families: \$10,000 aggregate*		
Doctors' Office Visits	\$0 after deductible	50% of negotiated fee plus all excess charges (after deductible)	
Professional Services (X-ray, lab, anesthesia, surgeon, etc.)	\$0 after deductible	50% of negotiated fee plus all excess charges (after deductible)	
Hospital Inpatient (Overnight Hospital Stays)	\$0 after deductible ²	All charges except \$650 per day (after deductible)	
Hospital Outpatient (If You Don't Stay Overnight)	\$0 after deductible ²	All charges except \$380 per day (after deductible)	
Emergency Room Services³	\$0 after deductible	All charges in excess of customary and reasonable fees (after deductible)	
Maternity	Not covered		
Preventive Care	Routine mammogram, Pap and PSA tests ⁴ : \$0 after deductible Well Baby and Well Child (through age 6): \$0 after deductible HealthyCheck SM Centers ⁵ : \$25/\$75 copay for basic/premium screening (deductible waived)	Routine mammogram, Pap and PSA tests ⁴ : 50% of negotiated fee plus all excess charges (after deductible) Well Baby and Well Child (through age 6): 50% of negotiated fee plus all excess charges (after deductible)	
Ambulance	\$0 after deductible	50% of negotiated fee plus all excess charges (after deductible)	
Physical and Occupational Therapy; Chiropractic Services	\$0 after deductible ⁶	All charges except \$25 per visit ⁶ (after deductible)	
Acupuncture/Acupressure	All charges except \$25 per visit, up to 24 visits per year (after deductible)		
Prescription Drugs (Blue Cross Formulary Drugs⁷) (Amounts shown are copays for each 30-day retail or mail order supply)	\$10 copay generic; \$30 copay brand-name ⁸ (after annual deductible) 30% of negotiated fee for self-administered injectables, except insulin (after annual deductible)	50% of drug limited fee schedule and all excess charges plus the copay/coinsurance as stated for in-network benefits (after deductible)	

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Blue Shield of California

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Benefits Grid For Shield Spectrum PPO Savings Plan 4000 (HSA)

Physician Office Visit	No Charge after deductible
Deductible	Individual:\$4,000
Coinsurance Level	0%
Out-of-Pocket Coinsurance Maximum	Individual:\$4,000, Includes deductible
<u>Lifetime Maximum</u>	\$6 Million per person

OUTPATIENT

Outpatient Prescription Drugs	No Charge after Medical Plan deductible
Emergency Room	No Charge after Deductible
Periodic Health Exam	\$35 Copay, No Charge after deductible
Periodic OB-GYN Exam	\$35 Copay, No Charge after deductible
Lab/X-Ray	No Charge after deductible
Outpatient Surgery	No Charge after deductible
Maternity - Prenatal/Postnatal	Not Covered
Well Baby Care (Child Health Supervision Services)	\$35 Copay, No Charge after deductible
Physical Therapy	No Charge after deductible
Skilled Nursing	No Charge in hospital or freestanding SNF
Home Health Care	No Charge after Deductible (Max 90 per Year)
Mental Health Office Visits	No Charge after deductible. Limitations: 20 Visits Per Year

INPATIENT

Inpatient Hospitalization	No Charge after deductible
Maternity	Not Covered
Mental Health	No Charge after Deductible
Chemical Dependency	No Charge after Deductible

This benefits grid only highlights some of the provisions of this plan and may vary in your state. There are many other important plan provisions, including exclusions, eligibility requirements, limitations and renewal terms. Please review it carefully before you apply for coverage.

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