

**This summary created by Cuesta College Insurance Benefits for illustrative purposes only.
Please refer to the Evidence of Coverage booklet when determining your benefits.**

BLUE SHIELD PLANS JANUARY 1, 2006	Choice A Shield Spectrum PPO 250-90/70 Premier		Choice B Shield Spectrum PPO 500- 80/60 Premier		Choice C Shield Spectrum PPO Savings Plus 2250	
	Preferred Providers	Non-Preferred Providers	Preferred Providers	Non-Preferred Providers	Preferred Providers	Non-Preferred Providers
Services						
Deductibles[#] (All providers combined)	\$250 per individual / \$500 per family		\$500 per individual / \$1000 per family		\$2,250 per individual/\$4,500 per family	
Calendar-Year Co-payment Maximum[#]	\$1,000 per individual / \$3,000 per family	\$3,000 per individual/ \$6,000 per family	\$3,000 per individual/ \$6,000 per family	\$10,000 individual/ \$20,000 per family	Calendar-Year Out-of-pocket Maximum \$3,000 per individual/\$5,500 per family (Includes the plan deductible)	
Lifetime Maximum	\$6,000,000		\$6,000,000		\$6,000,000	
Professional Services						
Physician & specialist office visits	\$10/visit*	30% [#]	\$25/visit*	30% [#]	20%	50%
Laboratory & X-Rays	\$10/visit	30%	\$25/visit	30%	20%	50%
Allergy testing & treatment	10%	30%	10%	30%	20%	50%
Diagnostic testing	10%	30%	10%	30%	20%	50%
Preventive Care						
Annual physical exam	Includes eye/ear screenings & immunizations according to age schedule		Includes eye/ear screenings & immunizations according to age schedule		One per calendar year, age 3 and older. Not subject to the plan's calendar year deductible	
	\$10/visit*	Not covered	\$25/visit*	Not covered	\$35	Not covered
Laboratory, including mammogram & Pap test screening or other FDA-approved cervical cancer screening tests (one per year)	\$10/visit*	Not covered	\$25/visit*	Not covered	Includes immunizations & vaccinations	
					20%	Not covered
Well-baby care						
Office visits & consultations	Includes: eye/ear screenings, immunizations, vaccinations		Includes: eye/ear screenings, immunizations, vaccinations		Birth to age 2. Not subject to the calendar year deductible	
	\$10/visit*	Not covered	\$25/visit*	Not covered	35%	Not covered
Immunizations (not subject to deductible)					20%	Not covered
Laboratory	\$10/visit	Not covered	\$25/visit	Not covered	20%	Not covered
Outpatient Services						
Outpatient surgery in hospital/facility	10%	30% [#]	\$50/surgery [#] + 10%	30%	20%	50%
Outpatient treatment, renal dialysis and necessary supplies	10%	30% [#]	10%	30% [#]	20%	50%
Hospitalization Services						
Inpatient physician services (including pregnancy and maternity care)	10%	30% [#]	10%	30%	20%	50%
Semi-private room and board, medically necessary services and supplies	10%	30% [#]	\$100/admission + 10%	30%	20%	50%
Skilled nursing facility (SNF) services						
Freestanding SNF	Combined maximum of up to 100 preauthorized days per calendar year; semi-private accommodations		Combined maximum of up to 100 preauthorized days per calendar year; semi-private accommodations		Combined maximum of up to 100 preauthorized days per calendar year; semi-private accommodations	
Hospital SNF Unit	10%	10% with prior authorization	10%	10% with prior authorization	20%	20% with prior authorization
	10%	30% [#]	10%	30%	20%	40%
Emergency Health Coverage						
Facility services (Not resulting in a direct admission)	\$100 [#]	\$100 [#]	\$50 [#] + 10%*		\$50 copay + 20%	\$50 copay + 20%
Facility services (Resulting in a direct admission)	10%	10%	10%	10%	20%	20%
Emergency room physician services	10%	10%	10%	10%	20%	20%
Ambulance Services	10%	10%	20%	10%		
			Plan payment up to \$2,000 maximum per calendar year		20%	50%
Durable Medical Equipment	10%	30%	10%	30%		
Mental Health Services (Psychiatric)	MHSA Participating Providers	MHSA Non-Participating Providers	MHSA Participating Providers	MHSA Non-Participating Providers	MHSA Participating Providers	MHSA Non-Participating Providers
Inpatient hospital facility services	10%	30% [#]	\$100/admission + 10%	30%	20%	50%
Outpatient visits for severe mental health conditions	\$10/visit*	30%	\$25/visit*	30% [#]	20%	50%
Outpatient visits for non-severe mental health conditions (Up to 20 visits per year combined with outpatient chemical dependency visits)	\$25/visit [#]	Not covered	\$25/visit [#]	Not covered	50%	Not covered
Chemical Dependency Services (Substance Abuse)	MHSA Participating Providers	MHSA Non-Participating Providers	MHSA Participating Providers	MHSA Non-Participating Providers	MHSA Participating Providers	MHSA Non-Participating Providers
Inpatient services for medical acute detoxification	see "Hospitalization Services"	see "Hospitalization Services"	see "Hospitalization Services"	see "Hospitalization Services"	see "Hospitalization Services"	see "Hospitalization Services"
Outpatient visits (Up to 20 visits per year combined with outpatient non-severe mental health visits)	\$25/visit [#]	Not covered	\$25/visit [#]	Not covered	50%	Not covered
	Preferred Providers	Non-Preferred Providers	Preferred Providers	Non-Preferred Providers	Preferred Providers	Non-Preferred Providers
Home Health Services	Combined maximum of up to 100 preauthorized days per calendar year		Combined maximum of up to 100 preauthorized days per calendar year		Combined maximum of up to 100 preauthorized days per calendar year. Includes home injectable treatment.	
Home health and home infusion care	10%	10% with prior authorization	10%	10% with prior authorization	20%	20% with prior authorization
Hospice						
Routine home care and inpatient respite care	No charge	No charge with prior authorization	No charge	No charge with prior authorization	No charge	No charge with prior authorization
24 hour continuous home care and general inpatient care	10%	10% with prior authorization	10%	10% with prior authorization	20%	20% with prior authorization
Alternative Care						
Chiropractic services	Up to 12 visits per calendar year		Up to 12 visits per calendar year		Up to 20 visits per calendar year	
	\$25/visit	30%	\$25/visit	30%	20%	50%
Acupuncture services	Up to 20 visits per calendar year		Up to 20 visits per calendar year		Up to 20 visits per calendar year; plan payment up to \$25/visit	
	\$25/visit	\$25/visit	\$25/visit	\$25/visit	20%	20%
Rehabilitative therapy services						
Outpatient visits	\$10/visit	30%	\$25/visit	30%	20%	50%
Pregnancy and maternity care						
Prenatal and postnatal physician office visits	10%	30% [#]	\$25/visit	30%	20%	50%
Family Planning						
Family planning counseling	\$10/visit*	Not covered	\$25/visit*	Not covered	20%	Not covered
Elective abortion, tubal ligation, vasectomy	10%	Not covered	10%	Not covered	20%	Not covered
Covered out-of-state benefits	10% or \$10 copay	30%	10% or \$25 copay	Not covered	20%	50%
Diabetes care						
Equipment, devices and non-testing supplies (For testing supplies see Prescription Drug Coverage.)	10%	30%	10%	30%	20%	50%
Self-management training and education	\$10/visit	30%	\$25/visit	30%	20%	50%
Outpatient Prescription Drugs	Retail	Mail Service	Retail	Mail Service	Subject to deductible	
Brand Name Deductible	\$150 per calendar year		\$150 per calendar year		20% at any retail pharmacy	
	\$10 Generic	\$20 Generic	\$10 Generic	\$20 Generic	See Home Health Care Services	
	\$20 Formulary	\$40 Formulary	\$20 Formulary	\$40 Formulary	Classified	Mgmt/ Conf.
	\$35 Non-Formulary	\$60 Non-Formulary	\$35 Non-Formulary	\$60 Non-Formulary	\$239.29	\$234.60
Home self-administered injectable medications (May require preauthorization from Blue Shield Pharmacy)	30%	Not covered	30%	Not covered	\$444.97	\$436.24
					\$694.92	\$681.29
Rates	Classified	Mgmt/ Conf.	Classified	Mgmt/ Conf.		
Single	\$392.05	\$384.36	\$330.67	\$324.19		
Two-Party	\$729.06	\$714.76	\$614.51	\$602.79		
Family	\$1,138.55	\$1,116.23	\$960.22	\$941.40		

[#] Co-payments and charges for services not accruing to the member's calendar year co-payment maximum continue to be the member's responsibility after the calendar-year co-payment maximum is reached. * Benefits are not subject to the calendar-year deductible

This sheet is a brief summary of benefits. For more detailed information, please refer to the complete Plan Description.