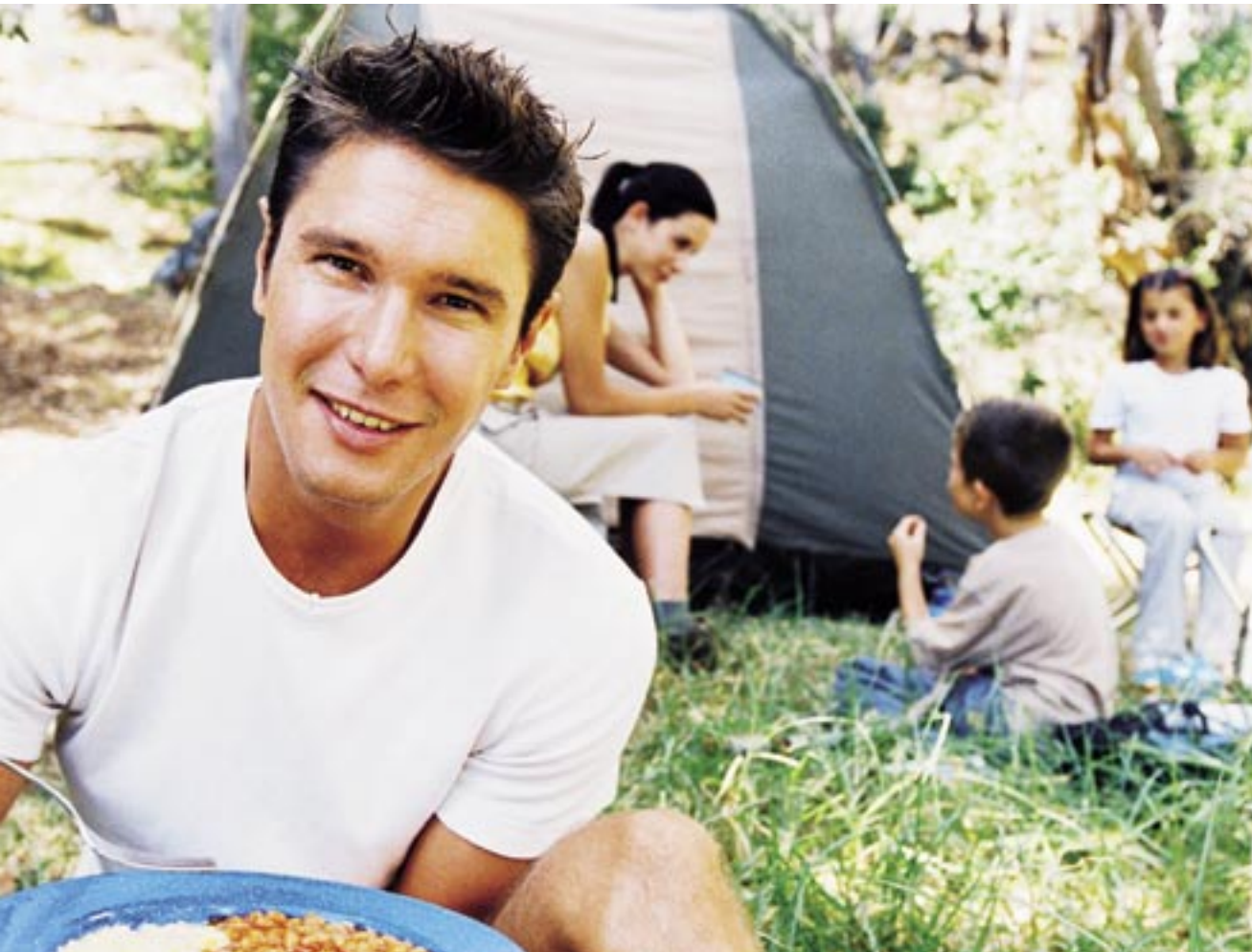




Blue Shield
of California



Choices for Your Lifestyle

A Guide to Our Health Plans for Individuals and Families
Combined Summary of Benefits and Provisions
Effective July 1, 2004

Visit us at mylifepath.com

Individual and Family Plans

An Independent Member of the Blue Shield Association

This booklet is only a summary of Blue Shield's health plans for individuals and families. It is not a contract. To review the Uniform Health Plan Benefits and Coverage Matrix (Uniform Matrix) for individual plans, please refer to the table of contents. The actual complete terms and conditions of the plans' benefits and coverage, limitations and exclusions are set forth in the applicable *Evidence of Coverage* and *Health Service Agreement* (EOC) or *Certificate of Insurance and Policy* (COI), which we will send you as soon as your application is approved. You have the right to receive a copy of the EOC/COI before you become a member. To request a copy, or if you have questions or need additional information, please call **(800) 431-2809**. Please read this booklet and the EOC/COI completely and carefully. If you have special healthcare needs, be sure to read the applicable sections of this summary and the EOC/COI before applying for coverage.

Please note: Some hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call the health plan at: PPO – (800) 431-2809 or HMO – (800) 424-6521, to ensure that you can obtain the healthcare services that you need.

The Help You Need is Just a Phone Call Away

This guide provides important information to help you make informed decisions about Blue Shield health coverage. Have questions? Need help choosing a plan or completing your application? Your Blue Shield agent can help.

Make the Right Decision Today: Protect Your Well-being with Blue Shield Health Coverage.

The value of having reliable health coverage shouldn't be underestimated. As a Blue Shield member, you will have coverage from a trusted organization that has provided affordable, flexible and dependable healthcare plans to millions of Californians.

We have developed strong relationships with hospitals and physicians, which means you will have access to one of California's largest provider networks including more than 45,000 physicians and over 350 hospitals. And you'll benefit from the rates we've negotiated for medical services with healthcare providers instead of being subject to any fees they may choose to charge.

Blue Shield plans also offer preventive care benefits to help you stay healthy, pharmacy coverage, personalized health and wellness support through www.mylifepath.com and outstanding customer service.

As you read this guide, think about the benefits and coverage that are important to you. Then choose the Blue Shield plan that works best for you and complete your application. It's that simple.



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You can't afford to be without health coverage. Let us show you why.

Health coverage helps protect you physically and financially. Having Blue Shield health coverage means you'll have access to over 45,000 doctors and more than 350 hospitals if you need medical care, and it also means you will only have to pay a small fraction of the total cost of your care. Since the doctors and hospitals in our networks have agreed to bill specific fees for their services (called "Allowable Amounts"), we can further protect you from the high costs you would be subject to without coverage.

The chart below shows the medical costs that could be incurred after a serious accident. We've also listed the costs you could pay and the percentage you would save if you have coverage through one of our plans.

An Example of Your Potential Savings for a Serious Accident

Services Rendered	Uninsured Billed Amount	Subscriber Costs			
		Shield Spectrum PPO Plan 5000	Shield Spectrum PPO Savings Plan 2400	Active Choice Plan 600	Access+ HMO Plan
Total Medical Costs (includes ambulance ride, ER visit, surgery, hospitalization, prescription drugs, physical therapy)	\$131,550	\$7,050	\$3,200	\$3,560	\$430
Annual Premiums/Dues	–	\$730	\$980	\$1,700	\$2,400
Total Costs		\$7,780	\$4,180	\$5,260	\$2,830
% Savings	–	94%	97%	96%	98%

Please note: These costs are estimates based on examples of medical charges and premiums/dues. Costs may vary depending on region and provider.

Health coverage helps protect you when you're well, too. The chart below shows the costs a healthy 25-year-old woman might pay in a calendar year for routine care, such as an annual physical exam, medical care for a sporting injury and prescription medications. Even without a major illness or injury, having a Blue Shield health plan can save you money.

An Example of Your Potential Savings for Routine Medical Expenses

Services Rendered	Uninsured Billed Amount	Subscriber Costs			
		Shield Spectrum PPO Plan 5000	Shield Spectrum PPO Savings Plan 2400	Active Choice Plan 600	Access+ HMO Plan
Deductible	–	\$5,000	\$2,400	None	\$1,500
ER visit for sporting injury	\$1,000	\$800	\$800	\$200	\$50
Dermatologist Office Visit	\$120	\$59	\$59	\$59	\$10
Annual Physical Exam	\$350	\$35	\$35	\$20	\$0
Generic Prescriptions (monthly birth control, seasonal allergies, acne medication)	\$830	\$170	\$127	\$204	\$170
Annual Premiums/Dues	–	\$480	\$650	\$1,150	\$1,800
Total Costs	\$2,300	\$1,544	\$1,671	\$1,633	\$2,030
% Savings	–	33%	27%	29%	12%

Please note: These costs are estimates based on examples of medical charges and premiums/dues. Costs may vary depending on region and provider.

Frequently Asked Questions

What kind of individual and family plans does Blue Shield offer?

Blue Shield offers an HMO (Health Maintenance Organization) plan called Access+ HMO,SM and a selection of PPO (Preferred Provider Organization) plans: Shield Spectrum PPOSM Plans, Shield Spectrum PPO Savings Plans and an Active ChoiceSM Plan 600.

Please Note: The Active Choice Plan 600 and Shield Spectrum PPO Plan 5000 are underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

What is the difference between an HMO and a PPO health plan?

There are many differences between an HMO and a PPO plan, but the most significant is how you access care. With an HMO plan, you and all eligible family members must live or work in an area served by Access+ HMO and access all your care through a designated Personal Physician that you choose. With one of our PPO plans, you may visit any licensed doctor without a referral from a Personal Physician.

With an HMO plan, you:

- Generally pay higher monthly dues so that your costs are lower whenever you access care throughout the year
- Receive many covered services at no charge or for a fixed copayment
- Choose a designated Personal Physician from our HMO network who provides, refers and coordinates your medical care
- Receive all medical services from providers in your Personal Physician's medical group or IPA (Independent Physician Association)
- Can go directly to an Access+ *Specialist*SM without a referral

- Live or work in a Access+ HMO Plan service area (identified in Blue Shield's HMO Directory)

With a PPO plan, you:

- Choose your own providers each time you seek medical care
- Generally pay lower monthly dues/premiums in exchange for higher out-of-pocket costs when you access care throughout the year
- Receive some preventive care benefits even before you meet your plan deductible
- Pay a percentage of charges for most covered services after you meet any applicable plan deductible
- Reduce your out-of-pocket costs when you use Blue Shield/Blue Shield Life's preferred provider network

What are the differences among Blue Shield's PPO plans?

Each of our PPO plans has a different calendar-year deductible and different benefit levels. As a general rule, the higher the calendar-year deductible for a plan, the lower the monthly dues/premiums. Plans with lower deductibles tend to have higher monthly dues/premiums, more generous prescription drug benefits and lower office visit copayments. Please see page 9 for a description of your Shield Spectrum PPO Plan choices. Also, our new Active Choice Plan 600 and PPO Plan 5000 offer something a little different than our other PPO plans.

Is preventive care covered?

Yes. All Blue Shield health plans cover preventive care such as routine physical exams, immunizations, well-baby care and annual gynecological exams before meeting any deductible.

Is my doctor included in Blue Shield's provider network?

Find out by going to the **Find a Provider** area of our Web site, www.mylifepath.com. You'll find every practitioner in the Blue Shield HMO and PPO networks and Blue Shield Life network, including hospitals, listed here. You'll also be able to locate mental health providers, dentists, optometrists, chiropractors and acupuncturists.

Can individual family members have different plans?

Yes. It may better suit some families' healthcare needs or budget to place family members on different types of plans. It's best to consult your agent to discuss which plan is right for each of your family members. Putting your child on his or her own plan with special YouthCareSM rates may also save you money. This can reduce your monthly dues/premiums compared to having a single family plan. Ask your agent about YouthCare.

Can I get dental coverage through Blue Shield?

Yes. If you're a Blue Shield member, you have the option to purchase the Dental PPO or Dental HMO dental plan at an additional cost. Access+ HMO offers Access+ *Dentist* at no extra charge, providing basic dental services. Please see page 31 for details.

Can I get life insurance through Blue Shield?

Yes. If you are approved for a health plan, you can purchase life insurance through Blue Shield Life to add to your coverage package without a separate approval process. Please see page 33 for more details.

Which plan is right for you?

Everyone's situation and needs differ when it comes to choosing a health plan. Here are some scenarios that might apply to you and can help point you toward the right health plan.

Kevin and Jennifer are married and own a small business. They go to the doctor for their regular check-ups, and prefer to pay lower monthly dues. Because they have enough in their savings, they feel comfortable paying a higher deductible in an emergency situation.

Plan to consider: Shield Spectrum PPO Savings Plan 4800 (see page 25)

- Why?**
- Lower-cost plan that provides catastrophic coverage in case of emergency
 - Preventive care services covered with a small copayment without having to meet the calendar-year deductible
 - Tax-saving Health Savings Account option if eligible (see page 33 for HSA details)

David is a recent college graduate who works for a friend's moving company. He goes to the doctor infrequently, but would like to continue going to the doctor he's always gone to. He takes a prescription medicine and wants a plan that covers most of that cost right away.

Plan to consider: A Shield Spectrum PPO Plan (see page 9)

- Why?**
- Choice of deductibles (the higher the deductible, the lower the monthly dues/premiums)
 - Automatic generic prescription drug coverage for a small copayment without meeting the calendar-year brand-name drug deductible
 - Freedom to visit Blue Shield preferred or non-preferred doctors and specialists for a flat or percentage copayment

Louisa works part time in retail sales and does not have health coverage through her employer. She goes to the doctor infrequently, but would like to get more day-to-day value from her plan. She is interested in going to the chiropractor and acupuncturist more often.

Plan to consider: Active Choice Plan 600 (see page 6)

- Why?**
- Annual \$600 credit to use towards payment for outpatient professional services without first meeting a deductible
 - If Louisa stays healthy and doesn't use up her annual credit, any remaining portion will carry over and be added to the next year's credit, giving her a larger amount of coverage credit to spend
 - Fixed copayment for generic prescription drugs without meeting the brand-name drug deductible
 - Preventive care services for \$20 copayments

Eric and Nicole are a young couple who want comprehensive coverage for themselves and their son. They don't go to the doctor often, but their son does. They want a plan that will make their son's healthcare costs predictable.

Plan to consider: PPO Plan 5000 for Eric and Nicole, and a separate Access+ HMO YouthCare plan for their son. (see pages 10 and 28)

- Why?**
- The Access+ HMO plan lets them take their son to the doctor as often as necessary and keep their out-of-pocket costs down
 - Fixed copayments for physician office visits, hospital services and prescription drugs, with no charge for preventive care services for their son
 - The PPO Plan 5000 covers Eric and Nicole in the event of an emergency and provides for their annual physical exams for a flat copayment before meeting their deductible
 - With two different plans, they can best meet their individual coverage needs
 - YouthCare rates reduce their monthly dues

Sam and Anna are a couple in their 50s who want a health plan that will cover the medical attention they may need, but with the lowest monthly premiums. They are aware of the health issues that often come with age, so they want a little extra protection just in case something happens.

Plan to consider: PPO Plan 5000 (see page 10)

- Why?**
- The plan's \$10,000 Critical Condition ProtectionSM (CCP) benefit will provide them with the added protection they may need in the future
 - They don't mind having a high-deductible plan that keeps their monthly premiums low because they can afford to pay the deductible if they have a high-cost medical event

Additional services add value to every plan!

At Blue Shield, we believe staying well is just as important as getting well. That's why we offer a wide selection of services, programs, tools and information to support our members' health.

Lifepath Advisers

*Lifepath Advisers*SM provides a convenient resource that members can turn to for immediate professional assistance with virtually any concern, personal or professional. These services are available to you automatically upon becoming a member, without any extra cost or paperwork.

Available 24 hours a day, seven days a week, *Lifepath Advisers* provides three types of services:

- **Nurseline.** Registered nurses offer medical information, assistance in choosing the most appropriate type of health care, self-care tips and lifestyle counseling.
- **Personal consultation.** Master's-level counselors offer support with issues like marriage and relationships, finding a balance between career and personal life, and mental health.
- **Work-life resources.** Sometimes you need help managing the impact of home and career. *Lifepath Advisers* offers a broad range of services including senior care, child care, family and relationship service, lifelong learning – even financial counseling and legal advice.

The Eye Care Network Discount Vision Program

When you use Eye Care Network (ECN) providers*, you will receive a 20 percent discount for a wide range of services and supplies.

Mylifepath Alternative Health Services Discount Program

Through the *Mylifepath*SM Alternative Health Services Discount Program, you can save money on alternative health and wellness services. This program provides members at least a 25 percent discount for acupuncture, chiropractic and massage therapy services.**

The *Mylifepath* network includes thousands of screened and qualified acupuncturists, chiropractors and massage therapists throughout California. Members can receive the discount by simply presenting their Blue Shield member ID card to any *Mylifepath* network practitioner and paying the lesser of 25 percent off the practitioner's usual published fee or the program's maximum fee schedule.

Mylifepath.com

Our innovative, award-winning Web site offers you valuable tools and reliable information to help you manage your health plan benefits. Once you become a member and register on mylifepath.com, you'll have access to:

- **My Health Plan:** Find out about your specific plan's benefits and services.
 - **Benefits At-A-Glance** allows you to view summaries of copayments, coinsurance and annual deductible amounts.
 - **Benefits A to Z** lets you browse by an alphabetical list of intuitive, user-friendly keywords.
 - **How to Use Your Benefits** provides easy-to-scan tips on preventive, emergency, maternity and specialist care.
 - **My Profile** helps you verify personal health plan information in one convenient location.
- **Nurse Chat:** Log on and talk with a registered nurse at any hour of the night or day about health matters large and small.
- **Lifepath Decision Guide**SM: Compare inpatient services and their cost at hospitals in your area, and find out about the treatment options for a diagnosed condition.
- **Find a Provider:** Find physicians, dentists, optometrists, chiropractors, hospitals, clinics and other healthcare providers. You can search by name,

specialty, gender, location or medical group. You can even print out directions.

- **Pharmacy:** Send your questions about prescription and over-the-counter drugs to a pharmacist at the University of California, San Francisco and receive your answer within two business days. Check for drugs listed in the formulary. Compare the costs of generic versus brand-name drugs and research drug interaction. Find a participating pharmacy near you.
- **Health & Wellness:** Search our Health Library for up-to-date information on common and rare illnesses from expert sources like the Mayo Clinic. And subscribe to our newsletter that offers something for almost every health issue throughout the year.

Health Management programs

Our health management programs provide up-to-date information and wellness strategies to help members take control of their health. And Blue Shield's Center for Health Improvement offers valuable programs and resources for members living with chronic conditions such as asthma and congestive heart failure. For more information about our health programs or publications, call us at **(800) 431-2809** or visit the Health & Wellness section of mylifepath.com.

* Discount program services are provided by the Eye Care Network (ECN). ECN network practitioners are screened, credentialed and managed by ECN. The Eye Care Network Discount Program is not a covered service of any Blue Shield health plan. None of the terms or conditions of Blue Shield health plans apply to the discount program. Members are responsible for all charges incurred and must pay the practitioner directly.

**The *Mylifepath* Alternative Health Services Discount Program is available only to Blue Shield members through an arrangement with American Specialty Health (ASH) Networks and is not a covered service of any Blue Shield health plan. ASH Networks credentials and manages the program's practitioners. None of the terms and conditions of Blue Shield's health plans apply. Blue Shield does not review the program's practitioners' services and products for medical necessity or efficacy and makes no representations or guarantees regarding their services or products.



Active Choice Plan 600

Manage your health with our distinctive PPO plan.



Do you want basic healthcare coverage without limiting your options in case of illness or injury?

If your answer is “yes,” then Active Choice Plan 600 might be right for you.

Active Choice keeps you covered in case of a potentially expensive medical event, while also taking care of your day-to-day healthcare needs. This plan delivers all the benefits you would expect from a health plan at lower, more affordable rates – with no deductibles.

Active Choice Plan 600 advantages

- No deductible to meet
- Affordable coverage with a wide choice of providers
- Annual \$600 credit (\$1,200 family) to use for the care you choose: hospital facility services and outpatient professional services, including acupuncture and chiropractic care
- Any unused portion of your current year’s credit will be added to your next year’s credit
- \$20 copayments for preventive care and \$12 copayments for generic drugs at participating pharmacies (please note – these copayments do not deduct from your \$600 annual credit)
- After the calendar-year copayment maximum is reached, Blue Shield will pay 100 percent of the allowable amount for all First Dollar services received from a preferred provider

How is Active Choice Plan 600 different?

This plan’s design gives you more control and more choice over how you manage your healthcare dollars. Each year a \$600 (\$1,200 family) credit is provided under this plan. You can use this money toward payment for any covered services, excluding preventive care and pharmacy services, which you always get for a flat copayment. If you don’t use up your credit, it will be carried over and added to your next year’s credit (\$600/\$1,200 maximum carryover). For example, if you spend only \$200 of your \$600 credit by the end of the year, the remaining \$400 will be added to your next \$600. You’ll then start the next year with a total credit of \$1,000 to use. By staying healthy, you won’t lose your credits – you’ll get to bank them to use in the next year.

Active Choice Plan 600

Uniform Health Plan Benefits & Coverage Matrix

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE CERTIFICATE OF INSURANCE AND POLICY SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Please note: Preferred hospitals are designated as either **Choice** or **Affiliate**, and different copayments may apply. Please see the Glossary for descriptions of **Choice** and **Affiliate** Hospitals.

ACTIVE CHOICE PLAN 600 This plan is underwritten by the Blue Shield of California Life & Health Insurance Company.	
CALENDAR-YEAR CREDIT	\$600 (\$1,200 Family)
CREDIT CARRYOVER POLICY (\$600/\$1,200 Max)	Active Choice members may carry over any unused portion of the \$600 (\$1,200 family) credit to the next calendar year. No individual member can use more than \$600 of the \$1,200 Family credit benefit.
CALENDAR-YEAR COPAYMENT MAXIMUM	\$3,500 (\$7,000 Family) with Preferred Choice Providers* All Providers \$5,000 (\$10,000 Family)
COPAYMENTS FOR PREVENTIVE CARE SERVICES ²	\$20 with Preferred Providers Not applicable with Non-Preferred Providers
COINSURANCE FOR ALL OTHER SERVICES	Member pays 100% of the allowable amount from Preferred Providers or the billed amount from Non-Preferred Providers before reaching the copayment maximum. Blue Shield then pays 100% of the allowable amount after the Copayment maximum is reached. ¹
CALENDAR-YEAR BRAND PRESCRIPTION DEDUCTIBLE	\$250 per person
LIFETIME BENEFIT MAXIMUM	\$6,000,000
* This copayment maximum also includes copayments from preferred providers when there is no designation of "Choice Hospitals" and "Affiliate Hospitals."	

PREVENTIVE CARE SERVICES

For the following services you will pay a \$20 copayment per visit with preferred providers, before or after you've met the copayment maximum. If you use a non-preferred provider, these services will not be covered by Blue Shield. Copayments for Preventive Care services do not count towards the calendar year copayment maximum or the \$600 (\$1,200 family) credit.

- Annual routine physical (including urinalysis, eye and ear screenings up to age 16) ^{~2}
- Annual gynecological exam office visit (including Pap test or other approved cervical cancer screening tests, and routine mammography with annual physical or in a separate office visit) ^{~2}
- Well-baby benefits (up to age 3, including tuberculin tests and immunizations) ^{~2}
- Immunizations (adult and child) and the immunizing agent

The following services are offered at no charge with preferred providers

- Osteoporosis screening
- Colorectal cancer screening

OUTPATIENT PRESCRIPTION DRUGS⁷ (oral contraceptives and diaphragms covered). There is a \$250 individual brand-name prescription drug deductible per year, which does not count towards the copayment maximum or deduct from the \$600 (\$1,200 family) credit.

	For drugs received from a Participating Pharmacy (30-day supply), you pay	For drugs received through the Mail Service, a Prescription Drug Program (60-day supply), you pay	For drugs received from a Non-Participating Pharmacy, you pay
Formulary generic drugs	\$12/prescription	\$24/prescription	Not Covered
Formulary brand-name drugs ⁸	\$30/prescription	\$60/prescription	Not Covered
Non-formulary brand-name drugs ⁸	\$45 or 50%/prescription (whichever is greater)	\$90 or 50%/prescription (whichever is greater)	Not Covered
Home self-administered injectables ⁹	30%	Not available	Not covered

FIRST DOLLAR SERVICES: ALL OTHER COVERED SERVICES**

You can use your \$600 (\$1,200 family) credit to pay for First Dollar services received from preferred providers. Please note that there are certain restrictions for services received from non-preferred providers. Once that credit is used, you will pay 100% of the allowable amount for services received from preferred providers or 100% of billed charges for services received from non-preferred providers until you meet the calendar-year copayment maximum. After the annual copayment maximum has been met, these services will be covered by Blue Shield at 100% until you reach the lifetime maximum.

PROFESSIONAL SERVICES

Physician office visits and visits to specialists, allergy testing and treatment

OUTPATIENT SERVICES²

Non-emergency services, surgery services received in a hospital outpatient or ambulatory surgery center, outpatient X-ray and lab services, speech therapy

HOSPITALIZATION SERVICES

Inpatient physician visits, inpatient semiprivate room and board, services, and subacute care

EMERGENCY HEALTH COVERAGE

Outpatient ER facility services, inpatient physician visits, inpatient semiprivate room and board, ambulance services

DURABLE MEDICAL EQUIPMENT (\$2,000 COMBINED MAXIMUM)³

Prosthetic appliances, home medical equipment and orthotic equipment

MENTAL HEALTH SERVICES^{4,5}

Inpatient hospital facility and physician services, outpatient visits for severe mental health conditions

HOME HEALTH SERVICES

Services received at home for an insured who is housebound and would otherwise require hospitalization (up to 90 visit max; prior authorization is required)

PREGNANCY AND MATERNITY CARE⁶

Outpatient prenatal and postnatal care, delivery and all necessary inpatient hospital services

FAMILY PLANNING

Consultations, tubal ligation, vasectomy, elective abortion, injectable contraceptives

REHABILITATION SERVICES

Provided by MD (in physician's office or a hospital outpatient department), or in the office of a physical therapist, certified occupational therapist or certified respiratory therapist

ACUPUNCTURE AND CHIROPRACTIC SERVICES

Up to 12 visits per calendar year combined, received from a chiropractor or acupuncturist

SKILLED NURSING FACILITY (SNF) AND SUBACUTE CARE

Semiprivate accommodations in a hospital or freestanding SNF unit (100 days max per calendar year)

OUT-OF-STATE SERVICES

Full plan benefits covered nationwide with the BlueCard program

DIABETES CARE

Diabetes care supplies, self-management training

Please Note: Benefits are subject to modification for subsequently enacted state or federal legislation.

∞ Copayment includes preventive lab services provided or ordered as part of exam. Diagnostic X-ray services, diagnostic examinations, pathology services and clinical laboratory services to diagnose illness or injury are not covered by the Preventive Care Services benefit.

** See the COI for a complete listing of all covered services.

- 1 Member is responsible for fixed dollar copayment or coinsurance in addition to any charges above allowable amounts. The coinsurance indicated is a percentage of the allowable amounts. Preferred providers accept Blue Shield's allowable amount as payment-in-full for covered services. Non-preferred providers can charge more than the allowable amounts. When members use non-preferred providers, they must pay the applicable copayment or coinsurance, plus any charges that exceed Blue Shield Life's allowable amount. Charges above the allowable amount do not count toward calendar-year copayment maximum. Mental health and substance abuse services, other than services for medical acute detoxification, are accessed through the Mental Health Services Administrator (MHSA) utilizing MHSA participating providers. MHSA participating providers agree to accept the MHSA's payment, plus Member's payment of any applicable copayment or coinsurance, or amounts in excess of benefit dollar maximums specified, as payment-in-full for covered mental health and substance abuse services. Inpatient services for medical acute detoxification are accessed utilizing Blue Shield's preferred and non-preferred (not MHSA) providers.
- 2 If the member's physician provides or orders any covered outpatient or out-of-hospital X-ray, laboratory or pathology services beyond those covered by the Preventive Care Services benefit, those services will only be considered for payment under the First Dollar Services section.
- 3 All covered orthotic, prosthesis and durable medical equipment and services have a combined benefit maximum of \$2,000 per member per calendar year, except those services covered under the Diabetes Care benefit and medically necessary oxygen.
- 4 For a listing of Severe Mental Illnesses including Serious Emotional Disturbances of a Child, and other benefit details, please refer to the COI and Policy.
- 5 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 substance abuse 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 Life preferred or non-preferred providers.
- 6 Members have coverage for inpatient benefits of no less than 48 hours following a normal delivery and no less than 96 hours following a delivery by cesarean section, unless the treating physician, in consultation with the mother, decides on an earlier discharge. See the COI for more information.
- 7 The drug formulary is a comprehensive list of recommended drugs, based on safety, efficacy, FDA bioequivalency and cost-effectiveness, and is reviewed and updated four times per year. Always present your Blue Shield ID Card to obtain benefits at a participating (network) pharmacy. Prescription drugs obtained from non-participating pharmacies are not covered. Call (800) 351-2465 to find out if a particular drug is on the Blue Shield drug formulary, or to request a copy of the formulary. For the most current information, you can access the formulary on the Blue Shield Web site at www.mylifepath.com.
- 8 If a member requests a brand-name drug or the physician states Dispense As Written (DAW), 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-name and generic drug. Member pays a copayment of 10% for formulary brand-name drugs. The 10% members' responsibility is calculated by taking Blue Shield's contracted rate, minus the dollar copayment, and then taking 10% of the remaining amount.
- 9 Home self-administered injectables are available through a network of participating pharmacies. They are only covered when obtained from a participating pharmacy, and they require prior authorization from Blue Shield Pharmacy Services.

Shield Spectrum PPO and Shield Spectrum PPO Savings Plans

Choose the PPO Plan with the calendar-year deductible and benefits that work best for you.



Do you want the freedom to choose your healthcare providers each time you seek care?

If your answer is “yes,” then a Shield Spectrum PPO plan might be right for you. You’ll have the freedom to visit the doctors and specialists you want to see. When you receive care from Blue Shield PPO healthcare providers your out-of-pocket costs are less.

Shield Spectrum PPO Plan advantages

- One of California’s largest PPO provider networks: over 45,000 doctors and more than 350 hospitals
- Many services with a fixed dollar or percentage copayment before you meet the deductible
- Wide range of annual deductibles
- Copayment maximums to help contain costs
- Added protection of \$10,000 in Critical Condition ProtectionSM (CCP) with the PPO Plan 5000*

Do you want protection against major healthcare expenses with the possibility of additional tax savings?

If your answer is “yes,” consider a Shield Spectrum PPO Savings Plan. It’s a highly affordable plan that offers many of the same advantages as the Shield Spectrum PPO plans.

Shield Spectrum PPO Savings Plan advantages

- Your out-of-pocket maximum includes your plan deductible, so you’ll only pay up to \$3,200 out of pocket for an individual, or \$5,800 total for two or more people in a calendar year
- Like all Blue Shield PPO plans, you can see the provider of your choice each time you seek care
- Preventive care on a fixed copayment basis before meeting any deductible
- Access to Blue Shield’s Prescription Value Program, a mail service pharmacy option, to help you save on prescription drugs that you buy at retail prices. Please call (800) 431-2809 to request a Prescription Value Program brochure.
- HSA eligibility. To learn more about HSAs, call (800) 431-2809.

Blue Shield PPO Plans at a Glance

Plan Options	Deductible	Copayments (with Preferred Physicians)	Percentage Copayments/Coinsurance (with Preferred Physicians)
PPO Plan 500	\$500 (\$1,000 family ¹)	\$30	25%
PPO Plan 750	\$750 (\$1,500 family ¹)	\$35	30%
PPO Plan 1500	\$1,500 (\$3,000 family ¹)	\$40	30%
PPO Plan 2000	\$2,000 (\$4,000 family ¹)	\$45	30%
PPO Plan 5000*	\$5,000 (\$10,000 family ¹)	\$35 (after meeting the deductible)	30%
PPO Savings Plan 2400 (4800 Family)	\$2,400 (\$4,800 family)	\$35 for annual preventive care office visit. Physician office visits are subject to the percentage copayment.	30%

* Critical Condition ProtectionSM (CCP) is embedded in the PPO Plan 5000. Members who have a first incident of severe heart attack, severe stroke or life-threatening cancer become eligible for this benefit. There are restrictions that apply. Proceeds paid to the subscriber from the CCP under this policy may be used for non-medical care expenses. Therefore, a portion of your monthly premium payment allocable to the CCP may not be tax deductible. Blue Shield does not provide tax advice and this cannot be considered tax advice. If you have any questions, you should contact your tax advisor.

¹ Two or more people. Represents a total of all applicable expenses accrued by covered family members. Family copayment maximums are only twice the individual amounts, no matter how many people are covered on the plan. Each covered individual in the family also has his or her own individual deductible, in case only one person needs expensive medical services.

Shield Spectrum PPO Plan 5000

Uniform Health Plan Benefits & Coverage Matrix

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE CERTIFICATE OF INSURANCE AND POLICY SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Plan benefits that are available before you need to meet the medical plan deductible are shown below in a shaded box. **Please note:** Preferred hospitals are designated as either **Choice** or **Affiliate**, and different copayments may apply. Please see the Glossary for descriptions of **Choice** and **Affiliate** Hospitals.

SHIELD SPECTRUM PPO PLAN 5000	
This plan is underwritten by the Blue Shield of California Life & Health Insurance Company.	
DEDUCTIBLE*	\$5,000 (\$10,000 Family)
COPAYMENTS	\$35 with Preferred Providers Not applicable with Non-Preferred Providers
COINSURANCE	30% with Preferred Choice Hospitals 40% with Preferred Affiliate Hospitals 50% with Non-Preferred Providers
CALENDAR-YEAR COPAYMENT MAXIMUM (Includes the plan deductible. Some services do not apply.)	Services with Preferred Choice Providers** \$7,000 (\$14,000 family) Services with All Providers: \$10,000 (\$20,000 family)
LIFETIME MAXIMUM	\$6,000,000
CRITICAL CONDITION PROTECTION	\$10,000 per member, per lifetime
* Benefits for covered brand-name drugs are subject to a separate \$500 brand-name drug deductible per person.	
** This copayment maximum also includes copayments or coinsurance paid from preferred providers when there is no designation of "Choice Hospital" and "Affiliate Hospital."	

COVERED SERVICES (subject to the plan deductible, unless noted)	MEMBER COPAYMENTS	
	With Preferred Providers, ¹ you pay	With Non-Preferred Providers, ¹ you pay
PROFESSIONAL SERVICES		
– Office visits, consultations, OB/GYN and specialist visits, second surgical opinions, urgent care services	\$35 copayment	50%
– Allergy testing and treatment	30%	50%
PREVENTIVE CARE		
– Annual Routine Physical Exam, Well-baby care office visits and Gynecological exam office visit (includes Pap test or other approved cervical cancer screening tests, routine mammography and immunizations when received as part of the annual exam or preventive care visit)	\$35 copayment	Not covered
OUTPATIENT SERVICES		
– Non-Emergency surgery in outpatient department of hospital	30% w/Choice Hospitals	40% w/Affiliate Hospitals
– Outpatient or Out-of-Hospital X-ray and Laboratory	30%	50%
– Non-Emergency surgery in an Ambulatory Surgery Center (ASC)	30%	50% ^{2,3}
– Radiological Procedure requiring prior authorization (such as CT scans, MRIs, MRAs, PET scans, Bone Densitometry and any cardiac diagnostic procedure utilizing Nuclear Medicine)	30%	50%

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, anesthesiologists, pathologists, radiologists – Inpatient semiprivate room and board, services and supplies and subacute care	30%	
	30% w/Choice Hospitals	40% w/Affiliate Hospitals
EMERGENCY HEALTH COVERAGE – Outpatient Emergency room facility services ⁴ – Inpatient physician visits, semiprivate room and board, services and supplies and subacute care not resulting in admission	50%	
	50% ^{2,3}	
AMBULANCE SERVICES (Surface or Air) ⁵	30%	
PRESCRIPTION DRUG COVERAGE ⁶ (outpatient; brand-name drugs are subject to a \$500 brand-name drug deductible per person, per calendar year; includes oral contraceptives and diaphragms and diabetic testing supplies) – Generic formulary drugs – Formulary brand-name drugs ⁷ – Non-formulary brand-name drugs ⁷ – Home Self-Administered Injectables ⁸	At Participating Pharmacies (Up to a 30-day supply) \$10/prescription ² \$30+10%/prescription (maximum copayment of \$60 per prescription) ² \$45 or 50% (whichever is greater) ² 30% ²	Mail Service Prescriptions (Up to a 60-day supply) \$20/prescription ² \$60+10% prescription (maximum copayment of \$150 per prescription) ² \$75 or 50% (whichever is greater) ² Not Covered
DURABLE MEDICAL EQUIPMENT – Prosthetic Appliances, Home Medical Equipment and Orthotic Equipment ⁹ – Diabetes Care Supplies	30%	
	50%	
	With MHPA Participating Providers,¹ you pay	With MHPA Non-Participating Providers,¹ you pay
MENTAL HEALTH SERVICES ^{10,11} – Inpatient Hospital Facility Services – Inpatient Physician 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 chemical dependency visits)	30%	
	30%	
	\$35 copayment	
	30%	
CHEMICAL DEPENDENCY SERVICES (Substance Abuse) ¹¹ – Inpatient Hospital Facility Services for medical acute detoxification – Inpatient Physician Services for medical acute detoxification – Outpatient visits (up to 20 visits per calendar year combined with non-severe mental health visits)	30% w/ Choice Hospitals	40% w/Affiliate Hospitals
	30%	
	30%	
	50% ^{2,3}	
	50%	
	Not Covered	
	50% ^{2,3}	
	50%	
	Not Covered	
COVERED SERVICES (subject to the plan deductible, unless noted)	MEMBER COPAYMENTS	
	With Preferred Providers, ¹ you pay	With Non-Preferred Providers, ¹ you pay
HOME HEALTH SERVICES (up to 90 preauthorized visits per calendar year)	30%	
	30% (after Blue Shield prior authorizes)	

COVERED SERVICES (subject to the plan deductible, unless noted)	MEMBER COPAYMENTS	
	With Preferred Providers, ¹ you pay	With Non-Preferred Providers, ¹ you pay
OTHER Pregnancy and Maternity Care¹² – Outpatient prenatal and postnatal care – Delivery and all necessary inpatient hospital services	30%	
	30% w/Choice Hospitals	40% w/Affiliate Hospitals
Family Planning – Consultations, tubal ligation, vasectomy, elective abortion – Injectable Contraceptives ¹³	30%	
	\$25 copayment ²	
Rehabilitation Services – Physical, occupational or respiratory therapy received in a provider's office or outpatient department of a hospital (12 visit combined max/ calendar year for rehabilitation and speech therapy services)	30%	
Speech Therapy (12 visit combined max/calendar year for rehabilitation and speech therapy services) – Received in a provider's office or outpatient department of a hospital – Received from a licensed speech therapist	30%	
	30%	
Skilled Nursing Facility (SNF) and Subacute Care (semiprivate accommodations following transfer from hospital unless Blue Shield gives written authorization; up to 100 days per calendar year)	30% in hospital or freestanding SNF	
Out-of-State Services (full plan benefits covered nationwide with the BlueCard program)	30% with BlueCard Participating Providers	
Diabetes Care – Diabetes Self-Management Training	50% ² in hospital SNF 30% in freestanding SNF	
	50% with all other providers	
Diabetes Care – Diabetes Self-Management Training	\$35 copayment	
	50%	
Dental Services and Life Insurance (Optional dental benefits and life insurance are available. See pages 31-33 for details.)		

Please Note: Benefits are subject to modification for subsequently enacted state or federal legislation.

† The brand-name drug deductible is separate from the medical plan deductible.

1 Member is responsible for fixed dollar or percentage copayment in addition to any charges above allowable amounts. The copayment percentage indicated is a percentage of the allowed amounts. Preferred providers accept Blue Shield allowable amounts as payment-in-full for covered services. Non-preferred providers can charge more than these amounts. When members use non-preferred providers, they must pay the applicable copayment percentage of the allowable amount plus any charges that exceed Blue Shield's allowable amount. Charges above the allowable amount do not count toward the plan deductible or copayment maximum. Mental health and chemical dependency services, other than services for medical acute detoxification, are accessed through the Mental Health Services Administrator (MHSA) utilizing MHSA participating providers. MHSA participating providers agree to accept the MHSA's payment, plus Member's payment of any applicable deductible and copayment, or amounts in excess of benefit dollar maximums specified, as payment-in-full for covered mental health and substance abuse services. Inpatient services for medical acute detoxification are accessed through Blue Shield utilizing Blue Shield's preferred and non-preferred (not MHSA) providers.

2 These copayments do not count toward the copayment maximum and will continue to be charged once it is reached.

3 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.

4 Members pay the preferred provider percentage copayment level, 30%, for physician services received during an emergency room visit.

5 Members who reasonably believe that they have an emergency medical condition which requires an emergency response are encouraged to appropriately use the 911 emergency response system where available.

6 The drug formulary is a comprehensive list of recommended drugs, based on safety, efficacy, FDA bioequivalency and cost-effectiveness, and is reviewed and updated four times per year. Always present your Blue Shield ID Card to obtain benefits at a participating (network) pharmacy. Prescription drugs obtained from non-participating pharmacies are not covered. Call (800) 351-2465 to find out if a particular drug is on the Blue Shield drug formulary, or to request a copy of the formulary. For the most current information, you can access the formulary on the Blue Shield Web site at www.mylifepath.com.

7 If a member requests a brand-name drug or the physician states Dispense As Written (DAW), 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. Member pays a copayment of 10% for formulary brand-name drugs. The 10% members' responsibility is calculated by taking Blue Shield's contracted rate, minus the dollar copayment, and then taking 10% of the remaining amount.

8 Home self-administered injectables are available through a network of participating pharmacies. They are only covered when obtained from a participating pharmacy, and they require prior authorization from Blue Shield Pharmacy Services.

9 All covered orthotic equipment and services have a benefit maximum of \$2,000 per member per calendar year, except those services covered under the Diabetes Care benefit.

10 For a listing of Severe Mental Illnesses including Serious Emotional Disturbances of a Child and other benefit details, please refer to the COI.

11 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.

12 Members have coverage for inpatient benefits of no less than 48 hours following a normal delivery and no less than 96 hours following a delivery by cesarean section, unless the treating physician, in consultation with the mother, decides on an early discharge.

13 Member is responsible for the office visit copayment in addition to the \$25 copayment.

Shield Spectrum PPO Plan 2000

Uniform Health Plan Benefits & Coverage Matrix

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Plan benefits that are available before you need to meet the medical plan deductible are shown below in a shaded box. **Please note:** Preferred hospitals are designated as either **Choice** or **Affiliate**, and different copayments may apply. Please see the Glossary for descriptions of **Choice** and **Affiliate** Hospitals.

Blue Shield of California and Blue Shield of California Life & Health Insurance Company each offer the Shield Spectrum PPO Plan 2000. The plan benefits and rates are identical. Please call (800) 431-2809 for more information.

DEDUCTIBLE*	\$2,000 (\$4,000 Family)	
COPAYMENTS	\$45 with Preferred Providers Not applicable with Non-Preferred Providers	
PERCENTAGE COPAYMENTS	30% with Preferred Choice Hospitals 40% with Preferred Affiliate Hospitals 50% with Non-Preferred Providers	
CALENDAR-YEAR COPAYMENT MAXIMUM (Does not include the plan deductible.)	Services with Preferred Choice Providers**	\$5,000 (\$10,000 family)
	Services with All Providers:	\$7,000 (\$14,000 family)
LIFETIME MAXIMUM	\$6,000,000	
TOTAL ANNUAL OUT-OF-POCKET COSTS	Deductible + copayment maximum	
* Benefits for covered brand-name drugs are subject to a separate \$250 brand-name drug deductible per person.		
** This copayment maximum also includes copayments from preferred providers when there is no designation of "Choice Hospital" and "Affiliate Hospital."		

COVERED SERVICES (subject to the plan deductible, unless noted)	MEMBER COPAYMENTS	
	With Preferred Providers, ¹ you pay	With Non-Preferred Providers, ¹ you pay
PROFESSIONAL SERVICES – Office visits, consultations, OB/GYN and specialist visits, second surgical opinions, urgent care services – Allergy testing and treatment	\$45 copayment ² 30%	50% 50%
PREVENTIVE CARE – Annual Routine Physical Exam, Well-baby care office visits and Gynecological exam (includes Pap test or other approved cervical cancer screening tests, routine mammography and immunizations when received as part of the annual exam or preventive care visit)	\$45 copayment ²	Not Covered
OUTPATIENT SERVICES – Non-Emergency services and procedures, Outpatient surgery in hospital – Outpatient or Out-of-Hospital X-ray and Laboratory – Non-Emergency surgery in an Ambulatory Surgery Center (ASC) – Radiological Procedure requiring prior authorization (such as CT scans, MRIs, MRAs, PET scans, Bone Densitometry and any cardiac diagnostic procedure utilizing Nuclear Medicine)	30% w/Choice Hospitals 30% 30%	40% w/Affiliate Hospitals 50% ^{2,3} 50% 50%

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, anesthesiologists, pathologists, radiologists – Inpatient semiprivate room and board, services and supplies and subacute care	30%	
	30% w/ Choice Hospitals	40% w/Affiliate Hospitals
EMERGENCY HEALTH COVERAGE – Outpatient Emergency room facility services, ⁴ Inpatient physician visits, semiprivate room and board, services and supplies and subacute care not resulting in admission	30%	50% ^{2,3}
AMBULANCE SERVICES (Surface or Air) ⁵	30%	30%
PRESCRIPTION DRUG COVERAGE⁶ (outpatient; brand-name drugs are subject to a \$250 brand-name drug deductible per person, per calendar year; includes oral contraceptives and diaphragms, and diabetic testing supplies) – Generic formulary drugs – Formulary brand-name drugs ⁷ – Non-formulary brand-name drugs ⁷ – Home Self-Administered Injectables ⁸	At Participating Pharmacies (up to a 30-day supply) \$10/prescription ² \$30+10%/prescription (maximum copayment of \$60 per prescription) ² \$45+10% (maximum copayment of \$100 per prescription) ² 30% ²	Mail Service Prescriptions (up to a 60-day supply) \$20/prescription ² \$60+10% prescription (maximum copayment of \$90 per prescription) ² \$75+10% (maximum copayment of \$150 per prescription) ² Not Covered
	DURABLE MEDICAL EQUIPMENT – Prosthetic Appliances, Home Medical Equipment and Orthotic Equipment ⁹ – Diabetes Care Supplies	30% 30%
With MHA Participating Providers,¹ you pay		With MHA Non-Participating Providers,¹ you pay
MENTAL HEALTH SERVICES^{10,11} – Inpatient Hospital Facility Services – Inpatient Physician 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 chemical dependency visits)	30%	
	30%	
	\$45 copayment ²	
	30%	
CHEMICAL DEPENDENCY SERVICES (Substance Abuse) ¹¹ – Inpatient Hospital Facility Services for medical acute detoxification – Inpatient Physician Services for medical acute detoxification – Outpatient visits (up to 20 visits per calendar year combined with non-severe mental health visits)	30% w/Choice Hospitals	40% w/Affiliate Hospitals
	30%	
	30%	
With Non-Preferred Providers,¹ you pay		With MHA Non-Participating Providers,¹ you pay
MENTAL HEALTH SERVICES^{10,11} – Inpatient Hospital Facility Services – Inpatient Physician 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 chemical dependency visits)	30%	
CHEMICAL DEPENDENCY SERVICES (Substance Abuse) ¹¹ – Inpatient Hospital Facility Services for medical acute detoxification – Inpatient Physician Services for medical acute detoxification – Outpatient visits (up to 20 visits per calendar year combined with non-severe mental health visits)	50% ^{2,3} 50% Not Covered	
With Preferred Providers,¹ you pay		With Non-Preferred Providers,¹ you pay
HOME HEALTH SERVICES (up to 90 preauthorized visits per calendar year)	30%	30% (after Blue Shield prior authorizes)

COVERED SERVICES (subject to the plan deductible, unless noted)	MEMBER COPAYMENTS	
	With Preferred Providers, ¹ you pay	With Non-Preferred Providers, ¹ you pay
OTHER Pregnancy and Maternity Care¹² – Outpatient prenatal and postnatal care – Delivery and all necessary inpatient hospital services	30%	
	30% w/Choice Hospitals	40% w/Affiliate Hospitals
		50% 50% ^{2,3}
Family Planning – Consultations, tubal ligation, vasectomy, elective abortion – Injectable Contraceptives ¹³	30%	
	\$25 copayment ²	
		Not Covered Not Covered
Rehabilitation Services – Physical, occupational or respiratory therapy received in a provider's office or outpatient department of a hospital	30%	
		50%
Chiropractic Services (up to 12 visits per calendar year) – Received from a chiropractor	50% up to \$25 (member responsible for all charges over \$25)	
		Not Covered
Skilled Nursing Facility (SNF) and Subacute Care (semiprivate accommodations following transfer from hospital unless Blue Shield gives written authorization; up to 100 days per calendar year)	30% in hospital or freestanding SNF	
		50% ² in hospital SNF 30% in freestanding SNF
Out-of-State Services (full plan benefits covered nationwide with the BlueCard program)	30% with BlueCard Participating Providers	
		50% with all other providers
Diabetes Care – Diabetes Self-Management Training	\$45 copayment ²	
		50%
Dental Services and Life Insurance (Optional dental benefits and life insurance are available. See pages 31-33 for details.)		

Please Note: Benefits are subject to modification for subsequently enacted state or federal legislation.

‡ The brand-name drug deductible is separate from the medical plan deductible.

- Member is responsible for fixed dollar or percentage copayment in addition to any charges above allowable amounts. The copayment percentage indicated is a percentage of the allowed amounts. Preferred providers accept Blue Shield allowable amounts as payment-in-full for covered services. Non-preferred providers can charge more than these amounts. When members use non-preferred providers, they must pay the applicable copayment percentage of the allowable amount plus any charges that exceed Blue Shield's allowable amount. Charges above the allowable amount do not count toward the plan deductible or copayment maximum. Mental health and chemical dependency services, other than services for medical acute detoxification, are accessed through the Mental Health Services Administrator (MHSA) utilizing MHSA participating providers. MHSA participating providers agree to accept the MHSA's payment, plus Member's payment of any applicable deductible and copayment, or amounts in excess of benefit dollar maximums specified, as payment-in-full for covered mental health and substance abuse services. Inpatient services for medical acute detoxification are accessed through Blue Shield utilizing Blue Shield's preferred and non-preferred (not MHSA) providers.
- These copayments do not count toward the copayment maximum and will continue to be charged once it is reached.
- 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.
- Members pay the preferred provider percentage copayment level, 30%, for physician services received during an emergency room visit.
- Members who reasonably believe that they have an emergency medical condition which requires an emergency response are encouraged to appropriately use the 911 emergency response system where available.
- The drug formulary is a comprehensive list of recommended drugs, based on safety, efficacy, FDA bioequivalency and cost-effectiveness, and is reviewed and updated four times per year. Always present your Blue Shield ID Card to obtain benefits at a participating (network) pharmacy. Prescription drugs obtained from non-participating pharmacies are not covered. Call (800) 351-2465 to find out if a particular drug is on the Blue Shield drug formulary, or to request a copy of the formulary. For the most current information, you can access the formulary on the Blue Shield Web site at www.mylifepath.com.
- If a member requests a brand-name drug or the physician states Dispense As Written (DAW), 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. Member pays a copayment of 10% for formulary brand-name drugs. The 10% members' responsibility is calculated by taking Blue Shield's contracted rate, minus the dollar copayment, and then taking 10% of the remaining amount.
- Home self-administered injectables are available through a network of participating pharmacies. They are only covered when obtained from a participating pharmacy, and they require prior authorization from Blue Shield Pharmacy Services.
- All covered orthotic equipment and services have a benefit maximum of \$2,000 per member per calendar year, except those services covered under the Diabetes Care benefit.
- For a listing of Severe Mental Illnesses including Serious Emotional Disturbances of a Child and other benefit details, please refer to the EOC.
- 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.
- Members have coverage for inpatient benefits of no less than 48 hours following a normal delivery and no less than 96 hours following a delivery by cesarean section, unless the treating physician, in consultation with the mother, decides on an early discharge.
- Member is responsible for the office visit copayment in addition to the \$25 copayment.

Shield Spectrum PPO Plan 1500

Uniform Health Plan Benefits & Coverage Matrix

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Plan benefits that are available before you need to meet the medical plan deductible are shown below in a shaded box. **Please note:** Preferred hospitals are designated as either **Choice** or **Affiliate**, and different copayments may apply. Please see the Glossary for descriptions of **Choice** and **Affiliate** Hospitals.

Blue Shield of California and Blue Shield of California Life & Health Insurance Company each offer the Shield Spectrum PPO Plan 1500. The plan benefits and rates are identical. Please call (800) 431-2809 for more information.

DEDUCTIBLE*	\$1,500 (\$3,000 Family)	
COPAYMENTS	\$40 with Preferred Providers Not applicable with Non-Preferred Providers	
PERCENTAGE COPAYMENTS	30% with Preferred Choice Hospitals 40% with Preferred Affiliate Hospitals 50% with Non-Preferred Providers	
CALENDAR-YEAR COPAYMENT MAXIMUM (Does not include the plan deductible.)	Services with Preferred Choice Providers**	\$4,500 (\$9,000 family)
	Services with All Providers:	\$6,500 (\$13,000 family)
LIFETIME MAXIMUM	\$6,000,000	
TOTAL ANNUAL OUT-OF-POCKET COSTS	Deductible + copayment maximum	
* Benefits for covered brand-name drugs are subject to a separate \$250 brand-name drug deductible per person.		
** This copayment maximum also includes copayments from preferred providers when there is no designation of "Choice Hospital" and "Affiliate Hospital."		

COVERED SERVICES (subject to the plan deductible, unless noted)	MEMBER COPAYMENTS	
	With Preferred Providers, ¹ you pay	With Non-Preferred Providers, ¹ you pay
PROFESSIONAL SERVICES – Office visits, consultations, OB/GYN and specialist visits, second surgical opinions, urgent care services – Allergy testing and treatment	\$40 copayment ² 30%	50% 50%
PREVENTIVE CARE – Annual Routine Physical Exam, Well-baby care office visits and Gynecological exam (includes Pap test or other approved cervical cancer screening tests, routine mammography and immunizations when received as part of the annual exam or preventive care visit)	\$40 copayment ²	Not Covered
OUTPATIENT SERVICES – Non-Emergency services and procedures, Outpatient surgery in hospital – Outpatient or Out-of-Hospital X-ray and Laboratory – Non-emergency surgery in an Ambulatory Surgery Center (ASC) – Radiological Procedure requiring prior authorization (such as CT scans, MRIs, MRAs, PET scans, Bone Densitometry and any cardiac diagnostic procedure utilizing Nuclear Medicine)	30% w/Choice Hospitals 30% 30%	40% w/Affiliate Hospitals 50% ^{2,3} 50% 50% ^{2,3} 50%

COVERED SERVICES (subject to the plan deductible, unless noted)	MEMBER COPAYMENTS	
	With Preferred Providers, ¹ you pay	With Non-Preferred Providers, ¹ you pay
OTHER Pregnancy and Maternity Care¹² – Outpatient prenatal and postnatal care – Delivery and all necessary inpatient hospital services	30%	
	30% w/Choice Hospitals	40% w/Affiliate Hospitals
Family Planning – Consultations, tubal ligation, vasectomy, elective abortion – Injectable Contraceptives ¹²	30%	
	\$25 copayment ²	
Rehabilitation Services – Physical, occupational or respiratory therapy received in a provider's office or outpatient department of a hospital	30%	50%
Chiropractic Services (up to 12 visits per calendar year) – Received from a chiropractor	50% up to \$25 (member responsible for all charges over \$25)	
Skilled Nursing Facility (SNF) and Subacute Care (semiprivate accommodations following transfer from hospital unless Blue Shield gives written authorization; up to 100 days per calendar year)	30% in hospital or freestanding SNF	50% ² in hospital SNF 30% in freestanding SNF
Out-of-State Services (full plan benefits covered nationwide with the BlueCard program)	30% with BlueCard Participating Providers	50% with all other providers
Diabetes Care – Diabetes Self-Management Training	\$40 copayment ²	50%
Dental Services and Life Insurance (Optional dental benefits and life insurance are available. See pages 31-33 for details.)		

Please Note: Benefits are subject to modification for subsequently enacted State or Federal legislation.

‡ The brand-name drug deductible is separate from the medical plan deductible.

1 Member is responsible for fixed dollar or percentage copayment in addition to any charges above allowable amounts. The copayment percentage indicated is a percentage of the allowed amounts. Preferred providers accept Blue Shield allowable amounts as payment-in-full for covered services. Non-preferred providers can charge more than these amounts. When members use non-preferred providers, they must pay the applicable copayment percentage of the allowable amount plus any charges that exceed Blue Shield's allowable amount. Charges above the allowable amount do not count toward the plan deductible or copayment maximum. Mental health and chemical dependency services, other than services for medical acute detoxification, are accessed through the Mental Health Services Administrator (MHSA) utilizing MHSA participating providers. MHSA participating providers agree to accept the MHSA's payment, plus Member's payment of any applicable deductible and copayment, or amounts in excess of benefit dollar maximums specified, as payment-in-full for covered mental health and substance abuse services. Inpatient services for medical acute detoxification are accessed through Blue Shield utilizing Blue Shield's preferred and non-preferred (not MHSA) providers.

2 These copayments do not count toward the copayment maximum and will continue to be charged once the copayment maximum is reached.

3 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.

4 Members pay the preferred provider percentage copayment level, 30%, for physician services received during an emergency room visit.

5 Members who reasonably believe that they have an emergency medical condition which requires an emergency response are encouraged to appropriately use the 911 emergency response system, where available.

6 The drug formulary is a comprehensive list of recommended drugs, based on safety, efficacy, FDA bioequivalency and cost-effectiveness, and is reviewed and updated four times per year. Always present your Blue Shield ID Card to obtain benefits at a participating (network) pharmacy. Prescription drugs obtained from non-participating pharmacies are not covered. Call (800) 351-2465 to find out if a particular drug is on the Blue Shield drug formulary, or to request a copy of the formulary. For the most current information, you can access the formulary on the Blue Shield Web site at www.mylifepath.com.

7 If a member requests a brand-name drug or the physician states Dispense As Written (DAW), when an equivalent generic drug is available, and the brand-name drug deductible has been satisfied, the member pays the generic copayment plus the difference between the brand and generic drug cost. Member pays a copayment plus 10% for formulary brand-name drugs. The 10% members' responsibility is calculated by taking Blue Shield's contracted rate, minus the dollar copayment, and then taking 10% of the remaining amount.

8 Home self-administered injectables are available through a network of participating pharmacies. They are only covered when obtained from a participating pharmacy, and they require prior authorization from Blue Shield Pharmacy Services.

9 All covered orthotic equipment and services have a benefit maximum of \$2,000 per member per calendar year, except those services covered under the Diabetes Care benefit.

10 For a listing of Severe Mental Illnesses including Serious Emotional Disturbances of a Child and other benefit details, please refer to the EOC.

11 Blue Shield has contracted with a specialized healthcare 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.

12 Members have coverage for inpatient benefits of no less than 48 hours following a normal delivery and no less than 96 hours following a delivery by cesarean section, unless the treating physician, in consultation with the mother, decides on an early discharge.

13 Member is responsible for the office visit copayment in addition to the \$25 copayment.

Shield Spectrum PPO Plan 750

Uniform Health Plan Benefits & Coverage Matrix

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Plan benefits that are available before you need to meet the medical plan deductible are shown below in a shaded box. **Please note:** Preferred hospitals are designated as either **Choice** or **Affiliate**, and different copayments may apply. Please see the Glossary for descriptions of **Choice** and **Affiliate** Hospitals.

DEDUCTIBLE*	\$750 (\$1,500 Family)	
COPAYMENTS	\$35 with Preferred Providers Not applicable with Non-Preferred Providers	
PERCENTAGE COPAYMENTS	30% with Preferred Choice Hospitals 40% with Preferred Affiliate Hospitals 50% with Non-Preferred Providers	
CALENDAR-YEAR COPAYMENT MAXIMUM (Does not include the plan deductible.)	Services with Preferred Choice Providers**	\$4,000 (\$8,000 family)
	Services with All Providers:	\$6,000 (\$12,000 family)
LIFETIME MAXIMUM	\$6,000,000	
TOTAL ANNUAL OUT-OF-POCKET COSTS	Deductible + copayment maximum	
* Benefits for covered brand-name drugs are subject to a \$250 brand name-drug deductible per person.		
** This copayment maximum also includes copayments from preferred providers when there is no designation of "Choice Hospital" and "Affiliate Hospital."		

COVERED SERVICES (subject to the plan deductible, unless noted)	MEMBER COPAYMENTS	
	With Preferred Providers, ¹ you pay	With Non-Preferred Providers, ¹ you pay
PROFESSIONAL SERVICES – Office visits, consultations, OB/GYN and specialist visits, second surgical opinions, urgent care services – Allergy testing and treatment	\$35 copayment ² 30%	50% 50%
PREVENTIVE CARE – Annual Routine Physical Exam, Well-baby care office visits and Gynecological exam (includes Pap test or other approved cervical cancer screening tests, routine mammography and immunizations when received as part of the annual exam or preventive care visit)	\$35 copayment ²	Not Covered
OUTPATIENT SERVICES – Non-Emergency services and procedures, Outpatient surgery in hospital – Outpatient or Out-of-Hospital X-ray and Laboratory – Non-Emergency surgery in an Ambulatory Surgery Center (ASC) – Radiological Procedure requiring prior authorization (such as CT scans, MRIs, MRAs, PET scans, Bone Densitometry and any cardiac diagnostic procedure utilizing Nuclear Medicine)	30% w/Choice Hospitals 30% 30%	40% w/Affiliate Hospitals 50% ^{2,3} 50% 50% ^{2,3} 50%

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, anesthesiologists, pathologists, radiologists – Inpatient semiprivate room and board, services and supplies and subacute care	30%	
	30% w/Choice Hospitals	40% w/Affiliate Hospitals
EMERGENCY HEALTH COVERAGE – Outpatient Emergency room facility services, ⁴ Inpatient physician visits, semiprivate room and board, services and supplies and subacute care not resulting in admission	30%	50% ^{2,3}
AMBULANCE SERVICES (Surface or Air) ⁵	30%	30%
PRESCRIPTION DRUG COVERAGE⁶ (outpatient; brand-name drugs are subject to a \$250 brand-name drug deductible per person, per calendar year; includes oral contraceptives and diaphragms and diabetic testing supplies) – Generic formulary drugs – Formulary brand-name drugs ⁷ – Non-formulary brand-name drugs ⁷ – Home Self-Administered Injectables ⁸	At Participating Pharmacies (up to a 30-day supply) \$10/prescription ² \$30/prescription ² \$45+10% (maximum copayment of \$100 per prescription) ² 30% ²	Mail Service Prescriptions (up to a 60-day supply) \$20/prescription ² \$60/prescription ² \$75+10% (maximum copayment of \$150 per prescription) ² Not Covered
	DURABLE MEDICAL EQUIPMENT – Prosthetic Appliances, Home Medical Equipment and Orthotic equipment ⁹ – Diabetes Care Supplies	30%
	30%	50%
	With MHA Participating Providers,¹ you pay	With MHA Non-Participating Providers,¹ you pay
MENTAL HEALTH SERVICES^{10,11} – Inpatient Hospital Facility Services – Inpatient Physician 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 chemical dependency visits)	30%	
	30%	
	\$35 copayment ²	
	30%	
CHEMICAL DEPENDENCY SERVICES (Substance Abuse) ¹¹ – Inpatient Hospital Facility Services for medical acute detoxification – Inpatient Physician Services for medical acute detoxification – Outpatient visits (up to 20 visits per calendar year combined with non-severe mental health visits)	30% w/ Choice Hospitals	40% w/Affiliate Hospitals
	30%	
	30%	
		50% ^{2,3}
		50%
		50%
		Not Covered
		50% ^{2,3}
		50%
		Not Covered
COVERED SERVICES (subject to the plan deductible, unless noted)	MEMBER COPAYMENTS	
	With Preferred Providers, ¹ you pay	With Non-Preferred Providers, ¹ you pay
HOME HEALTH SERVICES (up to 90 preauthorized visits per calendar year)	30%	30% (after Blue Shield prior authorizes)

COVERED SERVICES (subject to the plan deductible, unless noted)	MEMBER COPAYMENTS	
	With Preferred Providers, ¹ you pay	With Non-Preferred Providers, ¹ you pay
OTHER Pregnancy and Maternity Care ² – Outpatient prenatal and postnatal care – Delivery and all necessary inpatient hospital services	30%	
	30% w/ Choice Hospitals	40% w/Affiliate Hospitals
		50% 50% ^{2,3}
Family Planning – Consultations, tubal ligation, vasectomy, elective abortion – Injectable Contraceptives ¹³	30%	
	\$25 copayment ²	
		Not Covered Not Covered
Rehabilitation Services – Physical, occupational or respiratory therapy received in a provider's office or outpatient department of a hospital	30%	
		50%
Chiropractic Services (up to 12 visits per calendar year) – Received from a chiropractor	50% up to \$25 (member responsible for all charges over \$25)	
		Not Covered
Skilled Nursing Facility (SNF) and Subacute Care (semiprivate accommodations following transfer from hospital unless Blue Shield gives written authorization; up to 100 days per calendar year)	30% in hospital or freestanding SNF	
		50% ² in hospital SNF 30% in freestanding SNF
Out-of-State Services (full plan benefits covered nationwide with the BlueCard program)	30% with BlueCard Participating Providers	
		50% with all other providers
Diabetes Care – Diabetes Self-Management Training	\$35 copayment ²	
		50%
Dental Services and Life Insurance (Optional dental benefits and life insurance are available. See pages 31-33 for details.)		

Please Note: Benefits are subject to modification for subsequently enacted State or Federal legislation.

‡ The brand-name drug deductible is separate from the medical plan deductible.

1 Member is responsible for fixed dollar or percentage copayment in addition to any charges above allowable amounts. The copayment percentage indicated is a percentage of the allowed amounts. Preferred providers accept Blue Shield allowable amounts as payment-in-full for covered services. Non-preferred providers can charge more than these amounts. When members use non-preferred providers, they must pay the applicable copayment percentage of the allowable amount plus any charges that exceed Blue Shield's allowable amount. Charges above the allowable amount do not count toward the plan deductible or copayment maximum. Mental health and chemical dependency services, other than services for medical acute detoxification, are accessed through the Mental Health Services Administrator (MHSA) utilizing MHSA participating providers. MHSA participating providers agree to accept the MHSA's payment, plus Member's payment of any applicable deductible and copayment, or amounts in excess of benefit dollar maximums specified, as payment-in-full for covered mental health and substance abuse services. Inpatient services for medical acute detoxification are accessed through Blue Shield utilizing Blue Shield's preferred and non-preferred (not MHSA) providers.

2 These copayments do not count toward the copayment maximum and will continue to be charged once the copayment maximum is reached.

3 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.

4 Members pay the preferred provider percentage copayment level, 30%, for physician services received during an emergency room visit.

5 Members who reasonably believe that they have an emergency medical condition which requires an emergency response are encouraged to appropriately use the 911 emergency response system where available.

6 The drug formulary is a comprehensive list of recommended drugs, based on safety, efficacy, FDA bioequivalency and cost-effectiveness, and is reviewed and updated four times per year. Always present your Blue Shield ID Card to obtain benefits at a participating (network) pharmacy. Prescription drugs obtained from non-participating pharmacies are not covered. Call (800) 351-2465 to find out if a particular drug is on the Blue Shield drug formulary, or to request a copy of the formulary. For the most current information, you can access the formulary on the Blue Shield of California Web site at www.mylifepath.com.

7 If a member requests a brand-name drug or the physician states Dispense As Written (DAW), when an equivalent generic drug is available, and the brand-name drug deductible has been satisfied, the member pays the generic copayment plus the difference between the brand and generic drug cost. Member pays a copayment plus 10% for the formulary brand-name drugs. The 10% members' responsibility is calculated by taking Blue Shield's contracted rate, minus the dollar copayment, and then taking 10% of the remaining amount.

8 Home self-administered injectables are available through a network of participating pharmacies. They are only covered when obtained from a participating pharmacy, and they require prior authorization from Blue Shield Pharmacy Services.

9 All covered orthotic equipment and services have a benefit maximum of \$2,000 per member per calendar year, except those services covered under the Diabetes Care benefit.

10 For a listing of Severe Mental Illnesses including Serious Emotional Disturbances of a Child and other benefit details, please refer to the EOC.

11 Blue Shield of California has contracted with a specialized healthcare 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.

12 Members have coverage for inpatient benefits of no less than 48 hours following a normal delivery and no less than 96 hours following a delivery by cesarean section, unless the treating physician, in consultation with the mother, decides on an early discharge.

13 Member is responsible for the office visit copayment in addition to the \$25 copayment.

Shield Spectrum PPO Plan 500

Uniform Health Plan Benefits & Coverage Matrix

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Plan benefits that are available before you need to meet the medical plan deductible are shown below in a shaded box. **Please note:** Preferred hospitals are designated as either **Choice** or **Affiliate**, and different copayments may apply. Please see the Glossary for descriptions of **Choice** and **Affiliate** Hospitals.

DEDUCTIBLE*	\$500 (\$1,000 Family)	
COPAYMENTS	\$30 with Preferred Providers Not applicable with Non-Preferred Providers	
PERCENTAGE COPAYMENTS	25% with Preferred Choice Hospitals 35% with Preferred Affiliate Hospitals 50% with Non-Preferred Providers	
CALENDAR-YEAR COPAYMENT MAXIMUM (Does not include the plan deductible.)	Services with Preferred Choice Providers**	\$3,500 (\$7,000 family)
	Services with All Providers:	\$5,000 (\$10,000 family)
LIFETIME MAXIMUM	\$6,000,000	
TOTAL ANNUAL OUT-OF-POCKET COSTS	Deductible + copayment maximum	
* Benefits for covered brand-name drugs are subject to a separate \$250 brand-name drug deductible per person.		
** This copayment maximum also includes copayments from preferred providers when there is no designation of "Choice Hospital" and "Affiliate Hospital."		

COVERED SERVICES (subject to the plan deductible, unless noted)	MEMBER COPAYMENTS		
	With Preferred Providers, ¹ you pay		With Non-Preferred Providers, ¹ you pay
PROFESSIONAL SERVICES – Office visits, consultations, OB/GYN and specialist visits, second surgical opinions, urgent care services – Allergy testing and treatment	\$30 copayment ²		50%
	25%		50%
PREVENTIVE CARE – Annual Routine Physical Exam, Well-baby care office visits and Gynecological exam (includes Pap test or other approved cervical cancer screening tests, routine mammography and immunizations when received as part of the annual exam or preventive care visit)	\$30 copayment ²		Not Covered
OUTPATIENT SERVICES – Non-Emergency services and procedures, Outpatient surgery in hospital – Outpatient or Out-of-Hospital X-ray and Laboratory – Non-Emergency surgery in an Ambulatory Surgery Center (ASC) – Radiological Procedure requiring prior authorization (such as CT scans, MRIs, MRAs, PET scans, Bone Densitometry and any cardiac diagnostic procedure utilizing Nuclear Medicine)	25% w/Choice Hospitals	35% w/Affiliate Hospitals	50% ^{2,3}
	25%		50%
	25%		50% ^{2,3}
	25%		50%

COVERED SERVICES (subject to the plan deductible, unless noted)	MEMBER COPAYMENTS	
	With Preferred Providers, ¹ you pay	With Non-Preferred Providers, ¹ you pay
OTHER		
Pregnancy and Maternity Care¹² – Outpatient prenatal and postnatal care – Delivery and all necessary inpatient hospital services	25%	50%
	25% w/Choice Hospitals	50% ^{2,3}
	35% w/Affiliate Hospitals	
Family Planning – Consultations, tubal ligation, vasectomy, elective abortion – Injectable Contraceptives ¹³	25%	Not Covered
	\$25 copayment ²	Not Covered
Rehabilitation Services – Physical, occupational or respiratory therapy received in a provider's office or outpatient department of a hospital	25%	50%
Chiropractic Services (up to 12 visits per calendar year) – Received from a chiropractor	50% up to \$25 (member responsible for all charges over \$25)	Not Covered
Skilled Nursing Facility (SNF) and Subacute Care (semiprivate accommodations following transfer from hospital unless Blue Shield gives written authorization; up to 100 days per calendar year)	25% in hospital or freestanding SNF	50% ² in hospital SNF 25% in freestanding SNF
Out-of-State Services (full plan benefits covered nationwide with the BlueCard program)	25% with BlueCard Participating Providers	50% with all other providers
Diabetes Care – Diabetes Self-Management Training	\$30 copayment ²	50%
Dental Services and Life Insurance (Optional dental benefits and life insurance are available. See pages 31-33 for details.)		

Please Note: Benefits are subject to modification for subsequently enacted State or Federal legislation.

‡ The brand-name drug deductible is separate from the medical plan deductible.

- Member is responsible for fixed dollar or percentage copayment in addition to any charges above allowable amounts. The copayment percentage indicated is a percentage of the allowed amounts. Preferred providers accept Blue Shield allowable amounts as payment-in-full for covered services. Non-preferred providers can charge more than these amounts. When members use non-preferred providers, they must pay the applicable copayment percentage of the allowable amount plus any charges that exceed Blue Shield's allowable amount. Charges above the allowable amount do not count toward the plan deductible or copayment maximum. Mental health and chemical dependency services, other than services for medical acute detoxification, are accessed through the Mental Health Services Administrator (MHSA) utilizing MHSA participating providers. MHSA participating providers agree to accept the MHSA's payment, plus Member's payment of any applicable deductible and copayment, or amounts in excess of benefit dollar maximums specified, as payment-in-full for covered mental health and substance abuse services. Inpatient services for medical acute detoxification are accessed through Blue Shield utilizing Blue Shield's preferred and non-preferred (not MHSA) providers.
- These copayments do not count toward the copayment maximum and will continue to be charged once the copayment maximum is reached.
- 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.
- Members pay the preferred provider percentage copayment level, 25%, for physician services received during an emergency room visit.
- Members who reasonably believe that they have an emergency medical condition which requires an emergency response are encouraged to appropriately use the 911 emergency response system where available.
- The drug formulary is a comprehensive list of recommended drugs based on safety, efficacy, FDA bioequivalency and cost-effectiveness, and is reviewed and updated four times per year. Always present your Blue Shield ID Card to obtain benefits at a participating (network) pharmacy. Prescription drugs obtained from non-participating pharmacies are not covered. Call (800) 351-2465 to find out if a particular drug is on the Blue Shield drug formulary, or to request a copy of the formulary. For the most current information, you can access the formulary on the Blue Shield of California Web site at www.mylifepath.com.
- If a member requests a brand-name drug or the physician states Dispense As Written (DAW), 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. Member pays a copayment plus 10% for formulary brand-name drugs. The 10% members' responsibility is calculated by taking Blue Shield's contracted rate, minus the dollar copayment, and then taking 10% of the remaining amount.
- Home self-administered injectables are available through a network of participating pharmacies. They are only covered when obtained from a participating pharmacy, and they require prior authorization from Blue Shield Pharmacy Services.
- All covered orthotic equipment and services have a benefit maximum of \$2,000 per member per calendar year, except those services covered under the Diabetes Care benefit.
- For a listing of Severe Mental Illnesses, including Serious Emotional Disturbances of a Child, and other benefit details, please refer to the EOC.
- Blue Shield of California has contracted with a specialized healthcare 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 providers.
- Members have coverage for inpatient benefits of no less than 48 hours following a normal delivery and no less than 96 hours following a delivery by cesarean section, unless the treating physician, in consultation with the mother, decides on an early discharge.
- Member is responsible for the office visit copayment in addition to the \$25 copayment.

Shield Spectrum PPO Savings Plan

Uniform Health Plan Benefits & Coverage Matrix

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

PPO Savings Plan benefits provided before you need to meet the deductible are shown in a shaded box. **Please note:** Preferred hospitals are designated as either **Choice** or **Affiliate**, and different copayments may apply. Please see the Glossary for descriptions of **Choice** and **Affiliate** Hospitals.

SHIELD SPECTRUM PPO SAVINGS PLAN	PPO SAVINGS PLAN 2400 (INDIVIDUAL)/4800 (FAMILY)
DEDUCTIBLE*	\$2,400 Individual/\$4,800 Family
CALENDAR-YEAR OUT-OF-POCKET MAXIMUM (Includes the plan deductible.) Please Note: The deductibles and out-of-pocket maximum amounts may increase annually to reflect federal cost-of-living adjustment.	\$3,200 Individual/\$5,800 Family
LIFETIME MAXIMUM	\$6,000,000
* For two-party/family coverage: Only after the family deductible is met will any individual be eligible for benefits. Adds together applicable expenses accrued by all covered family members.	

COVERED SERVICES (once the plan deductible has been met, unless noted)	MEMBER COPAYMENTS	
	With Preferred Providers, ¹ you pay	With Non-Preferred Providers, ¹ you pay
PROFESSIONAL SERVICES Physician services – Office visits, consultations, OB/GYN and specialist visits, second surgical opinions, allergy testing and treatment, urgent care services Laboratory, X-rays and diagnostics	30%	50%
PREVENTIVE CARE (not subject to the plan deductible, unless noted) – Annual Routine Physical Exam, Gynecological Exam, Well-baby care office visits – Annual Pap test or other approved cervical cancer screening tests and routine mammography, immunizations (with annual physical or in a separate office visit)	\$35 30%	Not Covered Not Covered
OUTPATIENT SERVICES – Outpatient hospital services and supplies	30% w/Choice Hospitals	40% w/ Affiliate Hospitals 50% (to \$300 per day) ²
HOSPITALIZATION SERVICES Inpatient Services – non-emergency – Inpatient physician visits and consultations, surgeons and assistants, anesthesiologists, pathologists, radiologists – Inpatient semiprivate room and board, services and supplies and subacute care services, received in a hospital or Ambulatory Surgery Center (ASC)	30% 30% w/Choice Hospitals	50% 40% w/Affiliate Hospitals 50% (to \$300 per day) ²
EMERGENCY HEALTH COVERAGE – Emergency room services ³ (\$75 copayment waived if the member is admitted directly to the hospital as an inpatient) – Inpatient physician and hospital services and supplies	\$75, then 30% 30%	\$75, then 30% 30%

COVERED SERVICES (once the plan deductible has been met, unless noted)	MEMBER COPAYMENTS	
	With Preferred Providers, ¹ you pay	With Non-Preferred Providers, ¹ you pay
AMBULANCE SERVICES (Surface or air) ⁴	30%	30%
PRESCRIPTION DRUG COVERAGE ⁵ (outpatient; subject to the plan deductible, oral contraceptives and diaphragms covered)	Coverage can be obtained at any retail pharmacy. Member pays full price and submits claims to Blue Shield of California. After medical deductible is met, 30% copayment applies. Prescriptions are available at reduced prices through the Prescription Value Program, a mail service pharmacy option.	
DURABLE MEDICAL EQUIPMENT – Prosthetic Appliances, Home Medical Equipment and Orthotic Equipment ⁶	30%	50%
	With MESA Participating Providers, ⁸ you pay	With MESA Non-Participating Providers, ⁸ you pay
MENTAL HEALTH SERVICES ^{7,8} – Inpatient Hospital Facility Services – Inpatient Physician 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 chemical dependency visits)	30% 30% 30%	50% (to \$300 per day) ² 50% Not Covered
CHEMICAL DEPENDENCY SERVICES (Substance Abuse) ⁸ – Inpatient Hospital Facility Services for medical acute detoxification – Inpatient Physician Services for medical acute detoxification – Outpatient visits (up to 20 visits per calendar year combined with non-severe mental health visits)	30% w/Choice Hospitals 30% 30%	40% w/Affiliate Hospitals 50% Not Covered
	With Preferred Providers, ¹ you pay	With Non-Preferred Providers, ¹ you pay
HOME HEALTH SERVICES (up to 90 preauthorized visits per calendar year)	30%	30%
OTHER Pregnancy and Maternity Care ⁹ – Outpatient prenatal and postnatal care – Delivery and all necessary inpatient hospital services	30% 30% w/Choice Hospitals	50% 50% (to \$300 per day) ²
Family Planning – Consultations, tubal ligation, vasectomy, elective abortion – Injectable Contraceptives ¹⁰	30% 30%	Not Covered Not Covered
Rehabilitation Services – Received in the office of a physician, physical therapist or occupational therapist or hospital outpatient department	30%	50%
Chiropractic Services (up to 12 visits per calendar year) – Received from a chiropractor ¹¹	50% up to \$25 (member responsible for all charges over \$25)	Not Covered
Skilled Nursing Facility (SNF) and Subacute Care (semiprivate accommodations following transfer from hospital unless Blue Shield gives written authorization; up to 100 days per calendar year)	30% in hospital or freestanding SNF	50% in hospital or freestanding SNF

COVERED SERVICES (once the plan deductible has been met, unless noted)	MEMBER COPAYMENTS	
	With Preferred Providers, ¹ you pay	With Non-Preferred Providers, ¹ you pay
Out-of-State Services (full plan benefits covered nationwide with the BlueCard program)	30% with BlueCard Participating Providers	50% with all other providers
Diabetes Care		
– Diabetes care supplies	30%	50%
– Diabetes Self-Management Training	30%	50%
Dental Services and Life Insurance (Optional dental benefits and life insurance are available. See pages 31-33 for details.)		

Please Note: Benefits are subject to modification for subsequently enacted state or federal legislation.

- 1 Member is responsible for fixed dollar or percentage copayment in addition to any charges above allowable amounts. The copayment percentage indicated is a percentage of the allowed amounts. Preferred providers accept Blue Shield's allowable amount as payment-in-full for covered services. Non-preferred providers can charge more than the allowable amounts. When members use non-preferred providers, they must pay the applicable copayment plus any charges that exceed Blue Shield's allowable amount. Charges above the allowable amount do not count toward the plan deductible or the calendar year out-of-pocket maximum. Mental health and substance abuse services, other than services for medical acute detoxification, are accessed through the Mental Health Services Administrator (MHSA) utilizing MHSA participating providers. MHSA participating providers agree to accept the MHSA's payment, plus Member's payment of any applicable deductible and copayment, or amounts in excess of benefit dollar maximums specified, as payment-in-full for covered mental health and substance abuse services. Inpatient services for medical acute detoxification are accessed through Blue Shield utilizing Blue Shield's preferred and non-preferred (not MHSA) providers.
- 2 For non-emergency hospital services and supplies received from a non-preferred (non-network) hospital, Blue Shield's maximum payment is \$300 per day. After the deductible is met, members are responsible for all charges that exceed \$300 per day.
- 3 Members pay the preferred provider level, 30%, for physician services received during an emergency room visit.
- 4 Members who reasonably believe that they have an emergency medical condition which requires an emergency response are encouraged to appropriately use the 911 emergency response system where available.
- 5 Includes coverage for medically necessary drugs, including drugs to treat diabetes.
- 6 All covered orthotic equipment and services have a benefit maximum of \$2,000 per member per calendar year, except those services covered under the Diabetes Care benefit.
- 7 For a listing of Severe Mental Illnesses including Serious Emotional Disturbances of a Child, and other benefit details, please refer to the EOC.
- 8 Blue Shield of California has contracted with a specialized health care service plan to act as our Mental Health Services Administrator (MHSA). The MHSA provides mental health and substance abuse 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 providers.
- 9 Members have coverage for inpatient benefits of no less than 48 hours following a normal delivery and no less than 96 hours following a delivery by cesarean section, unless the treating physician, in consultation with the mother, decides on an earlier discharge.
- 10 Member is responsible for the office visit copayment in addition to the 30% copayment.
- 11 Blue Shield will pay up to \$25 of the allowed charges. Member is responsible for all charges over \$25.

Blue Shield Access+ HMO Plan

An easy and efficient way to manage your health care and your costs.



Do you or your dependents go to the doctor often?

If your answer is “yes,” Access+ HMO might be the right plan for you. You’ll have access to a wide range of routine and preventive care services, prescription drug coverage and mental healthcare visits for a small copayment or for no out-of-pocket charge at all, without having to meet a deductible.

Please see the following Uniform Plan Matrix for specific benefit details.

Access+ HMO plan advantages

- \$10 office visit copayments
- Access to a specialist without a referral in your Personal Physician’s medical group/IPA for a \$30 copayment
- Preventive care provided at no extra charge
- Our HMO network has more than 25,000 doctors and 280 hospitals throughout California
- Basic dental benefits
- No lifetime maximum on plan benefits
- Virtually no claim forms

Personal care from your Personal Physician

Your relationship with the Personal Physician you choose is the key to your Access+ HMO plan. He or she will:

- Provide or coordinate your necessary medical services
- Arrange for referrals to specialists and hospitals and other covered non-physician healthcare practitioners
- Authorize medically necessary emergency services (your Personal Physician or his or her designee will be available 24 hours a day, seven days a week)

Access+ HMO Hospitals

Our Access+ HMO hospital network contains both **Choice** hospitals and **Affiliate** hospitals. *Non-emergency* services received from **Affiliate** hospitals may be subject to higher copayments. You can help control your costs by accessing **Choice** hospitals in the Blue Shield Provider Network. See the Uniform Matrix for copayment information.

Special features of the Access+ HMO plan

Self-referral to specialists

With Access+ *Specialist*SM you can go directly to a specialist or other physician in the same medical group or IPA as your Personal Physician, without a referral. When you self-refer, your copayment will be \$30 per covered office visit. To use the Access+ *Specialist* option, you must belong to a medical group or IPA that is an Access+ *Specialist* provider group.

Self-referrals to gynecological exams and OB/GYN visits

Women may go directly to an OB/GYN or family practice physician in the same medical group or IPA as their Personal Physician for obstetrical/gynecological services – including annual gynecological exams – without a referral. There is no charge for your annual gynecological office visit, but you will be charged your usual \$10 office visit copayment for other OB/GYN visits.

Money-back guarantee

Our member feedback program, *Access+ Satisfaction*, will refund your usual \$10 office visit copayment and provide a postage-paid postcard for your comments if you are ever dissatisfied with the service you receive during a covered office visit with an HMO network physician.

This is only an overview of the Blue Shield Access+ HMO plan. Please read this information so you will know from whom or what group of providers health care may be obtained. For complete information on the provisions of the Access+ HMO health plan, please read the Access+ HMO plan EOC. We will be happy to provide you with a copy.

Access+ HMO Plan

Uniform Health Plan Benefits & Coverage Matrix

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

All the benefits listed below are covered by the Access+ HMO Plan. Plan services and supplies are covered when performed, prescribed or authorized by your Personal Physician. Other than the exceptions listed on page 28, services that are not obtained from or approved by your Personal Physician will not be covered.

Benefits that are available before you meet any deductible are shown in a shaded box. **Please note:** Preferred hospitals are designated as either **Choice** or **Affiliate**, and different copayments may apply. Please see the Glossary for descriptions of **Choice** and **Affiliate** Hospitals.

DEDUCTIBLE*	\$1,500 (\$3,000 family)
CALENDAR-YEAR OUT-OF-POCKET MAXIMUM The calendar year out-of-pocket maximum includes the plan deductible.	\$3,000 (\$6,000 family)
LIFETIME MAXIMUM	No Limit

COVERED SERVICES ¹	MEMBER COPAYMENTS	
PROFESSIONAL SERVICES <ul style="list-style-type: none"> – Personal Physician office visits, specialists, OB/GYN services, urgent care, allergy testing and treatment – Allergy serum purchased separately for treatment – Injectable medications, lab and X-ray (Infertility injectables are not covered; insulin is covered under the outpatient prescription drug benefit) – Access+ <i>Specialist</i> (Self-referred physician office visits or other consultations only)² – Physician home visits 	<div style="text-align: center;"> <div style="background-color: #e0e0e0; padding: 2px; display: inline-block;">\$10/Visit[∞]</div> <div style="background-color: #e0e0e0; padding: 2px; display: inline-block;">50% of Allowed Amount[∞]</div> <div style="background-color: #e0e0e0; padding: 2px; display: inline-block;">No Charge</div> <div style="background-color: #e0e0e0; padding: 2px; display: inline-block;">\$30/Visit</div> <div style="background-color: #e0e0e0; padding: 2px; display: inline-block;">\$25/Visit[∞]</div> </div>	
PREVENTIVE CARE <ul style="list-style-type: none"> – Scheduled Routine Physical Exams, annual Gynecological Exam, immunizations, vision, hearing and routine lab screenings 	<div style="background-color: #e0e0e0; padding: 2px; display: inline-block;">No Charge</div>	
OUTPATIENT SERVICES Non-Emergency <ul style="list-style-type: none"> – Outpatient Surgery (in a hospital) – Outpatient Surgery (in an Ambulatory Surgery Center) – Outpatient Services and Supplies (in a hospital; includes radiation or intravenous chemotherapy treatment) – Outpatient Services and Supplies (in an Ambulatory Surgery Center; includes radiation or intravenous chemotherapy treatment) 	<div style="background-color: #e0e0e0; padding: 2px; display: inline-block;">\$150/Visit with Choice Hospitals[∞]</div> <div style="background-color: #e0e0e0; padding: 2px; display: inline-block;">\$250/Visit with Affiliate Hospitals[∞]</div> <div style="background-color: #e0e0e0; padding: 2px; display: inline-block;">\$150/Visit[∞]</div> <div style="background-color: #e0e0e0; padding: 2px; display: inline-block;">\$25/Visit with Choice Hospitals[∞]</div> <div style="background-color: #e0e0e0; padding: 2px; display: inline-block;">\$35/Visit with Affiliate Hospitals[∞]</div> <div style="background-color: #e0e0e0; padding: 2px; display: inline-block;">\$25/Visit[∞]</div>	
HOSPITALIZATION SERVICES <ul style="list-style-type: none"> – Inpatient physician visits and consultations, surgeons and assistants, anesthesiologists, pathologists, radiologists (covered inpatient hospital, skilled nursing facility and subacute care physician services) – Inpatient semiprivate room and board, intensive care units, subacute care, special treatment rooms, services and supplies 	<div style="background-color: #e0e0e0; padding: 2px; display: inline-block;">No Charge</div> <div style="background-color: #e0e0e0; padding: 2px; display: inline-block;">No Charge w/Choice Hospitals[∞]</div> <div style="background-color: #e0e0e0; padding: 2px; display: inline-block;">\$150/admit w/Affiliate Hospitals[∞]</div>	
EMERGENCY HEALTH COVERAGE <ul style="list-style-type: none"> – Emergency room services (\$50 copayment waived if the member is admitted directly to the hospital as an inpatient) – Inpatient hospital services and supplies 	<div style="background-color: #e0e0e0; padding: 2px; display: inline-block;">\$50/Visit[∞]</div> <div style="background-color: #e0e0e0; padding: 2px; display: inline-block;">No Charge w/Choice Hospitals[∞]</div> <div style="background-color: #e0e0e0; padding: 2px; display: inline-block;">\$150/admit w/Affiliate Hospitals[∞]</div>	
AMBULANCE SERVICES (Surface or Air) ³	<div style="background-color: #e0e0e0; padding: 2px; display: inline-block;">\$50/Trip[∞]</div>	
PRESCRIPTION DRUG COVERAGE⁴ (brand-name drugs subject to a \$150 brand-name drug deductible; includes coverage for formulary drugs, formulary oral contraceptives, diaphragms and diabetic testing supplies) <ul style="list-style-type: none"> – Generic drugs – Formulary brand-name drugs⁵ – Home Self-Administered Injectables⁶ 	At Participating Pharmacies (up to a 30-day supply) <div style="background-color: #e0e0e0; padding: 2px; display: inline-block;">\$10/prescription</div> <div style="background-color: #e0e0e0; padding: 2px; display: inline-block;">\$30/prescription</div> <div style="background-color: #e0e0e0; padding: 2px; display: inline-block;">20% (up to \$100/prescription)</div>	Mail Service Prescriptions (up to a 60-day supply) <div style="background-color: #e0e0e0; padding: 2px; display: inline-block;">\$20/prescription</div> <div style="background-color: #e0e0e0; padding: 2px; display: inline-block;">\$60/prescription</div> <div style="background-color: #e0e0e0; padding: 2px; display: inline-block;">Not covered</div>

COVERED SERVICES ¹	MEMBER COPAYMENTS
DURABLE MEDICAL EQUIPMENT – Prosthetics, Orthotics ⁷ and Home Medical Equipment	50%
MENTAL HEALTH SERVICES^{8,11} – Inpatient Hospital Facility Services – Inpatient Physician Services – Outpatient visits for severe mental health conditions ² – Outpatient visits for non-severe mental health conditions (up to 20 visits per calendar year combined with chemical dependency visits) ²	No Charge [∞] No Charge \$10/Visit [∞] \$25/Visit(\$30/visit if provider is MHSA Access+ <i>Specialist</i> provider)
CHEMICAL DEPENDENCY SERVICES (Substance Abuse)¹¹ – Inpatient hospital facility services for medical acute detoxification – Outpatient visits (up to 20 visits per calendar year combined with non-severe mental health visits) ²	No Charge w/Choice Hospitals [∞] \$150/Admit w/Affiliate Hospitals [∞] \$25/Visit (\$30/visit if provider is MHSA Access+ <i>Specialist</i> provider)
HOME HEALTH SERVICES (up to 100 visits per calendar year) – Home Health Agency visits (up to 4 visits per day, 2 hours per visit) – Consultations and evaluations by a licensed medical social worker, and medically necessary services or supplies which would be covered in the hospital	\$10/Visit [∞] No Charge
OTHER Pregnancy and Maternity Care^{9,10} – Outpatient prenatal and postnatal physician office visits – Delivery and all necessary inpatient hospital services	No charge No Charge w/Choice Hospitals [∞] \$150/Admit w/Affiliate Hospitals [∞]
Family Planning – Consultations – Tubal ligation, ¹⁰ elective abortion – Vasectomy – Injectable Contraceptives ¹²	\$10/Visit [∞] \$100 [∞] \$75 [∞] \$25 per injection [∞]
Rehabilitation Services – physical, occupational and respiratory therapy – Physician office visit or in hospital outpatient department – In Inpatient rehabilitation unit of hospital	\$10/Visit [∞] No Charge with Choice Hospitals [∞] \$150/admit with Affiliate Hospitals [∞]
Skilled Nursing Facility (SFN) and Subacute Care (subject to all of the inpatient hospital services provisions and limited to a benefit maximum of 100 days per calendar year; custodial care is not covered)	\$50/Day [∞]
Urgent Care (outside your Plan Service Area) ¹³	\$50/Visit [∞]
Diabetes Care – Diabetic Equipment (Diabetic testing supplies are covered under the Outpatient Prescription Drug benefit.) – Diabetes Self-Management Training	50% [∞] \$10/Day [∞]
Dental Services (for details please see the Dental Highlights Matrix, page 32) – Access+ <i>Dentist</i>	Embedded within this Plan
Other optional dental benefits are available for an additional cost through the Blue Shield Dental PPO or Dental HMO plans. See pages 31-32 for details.	

Please Note: Benefits are subject to modification for subsequently enacted state or federal legislation.

[∞] Copayments made for these services do accrue to the calendar year out-of-pocket maximum.

¹ Access+ HMO benefits are provided only for services that are medically necessary, as determined by the Personal Physician or Access+ HMO except in an emergency or as otherwise specified, and must be received while the patient is a current member. Mental health and substance abuse services are accessed through the Mental Health Services Administrator (MHSA) utilizing MHSA participating providers.

² To use the Access+ *Specialist* option, for other than mental health or substance abuse services, your Personal Physician must belong to a medical group or IPA that has decided to become an Access+ Provider Group. Access+ *Specialist* visits for mental health services for other than Severe Mental Illnesses or Serious Emotional Disturbances of a Child, and for Substance Abuse Care, will accrue towards the 20-visit-per-calendar-year maximum. In addition, all Access+ *Specialist* visits require a \$30 copayment per visit. Mental health and substance abuse Access+ *Specialist* visits are accessed through the MHSA utilizing MHSA participating providers.

³ Members who reasonably believe that they have an emergency medical condition which requires an emergency response are encouraged to appropriately use the 911 emergency response system where available.

⁴ Only medically necessary outpatient formulary drugs are covered. The drug formulary is a comprehensive list of recommended drugs based on safety, efficacy, FDA bioequivalency and cost-effectiveness, and is reviewed and updated four times per year. Always present your Blue Shield ID card to obtain benefits for prescription drugs at a participating pharmacy. Call Member Services to find out if a particular drug is on the formulary, or to request a copy of the formulary. The most current version of the formulary may be accessed on the Blue Shield of California Web site at www.mylifepath.com. Non-formulary drugs may be covered only if Blue Shield gives prior authorization. The prior authorization process takes a maximum of two days.

⁵ Only drugs in the Blue Shield Drug Formulary are covered. If a member or the physician requests a brand-name drug when an equivalent generic drug is available, the member pays the generic copayment plus the cost difference between the brand and generic drug at retail or mail order pharmacies.

⁶ Home self-administered injectables are available through a network of participating pharmacies. They are only covered when obtained from a participating pharmacy, and they require prior authorization from Blue Shield Pharmacy Services.

⁷ All covered orthotic equipment and services have a benefit maximum of \$2,000 per member per calendar year, except those services covered under the Diabetes Care benefit.

⁸ For a listing of Severe Mental Illnesses, including Serious Emotional Disturbances of a Child, and other benefit details, please refer to the EOC.

⁹ Except for the treatment of involuntary complications of pregnancy, pregnancy/maternity benefits for a pregnancy that qualifies as a Waiver Condition are not available during the six (6)-month period beginning as of the effective date of coverage. Coverage is applied for inpatient benefits of no less than 48 hours following a normal delivery and no less than 96 hours following a delivery by cesarean section, unless the treating physician, in consultation with the mother, decides on an early discharge.

¹⁰ The tubal ligation copayment does not apply when the procedure is performed in conjunction with delivery or abdominal surgery.

¹¹ Blue Shield of California has contracted with a specialized health care service plan to act as the Plan's Mental Health Services Administrator (MHSA) and to provide mental health and substance abuse services, other than inpatient services for medical acute detoxification, through a separate network of MHSA participating providers. Inpatient services for medical acute detoxification are accessed through Blue Shield utilizing HMO network providers. For all other mental health and substance abuse services, members should access MHSA participating providers.

¹² Member is responsible for the office visit copayment in addition to the \$25 copayment for the injectable contraceptives.

¹³ Authorization by Blue Shield is required for more than two out-of-area follow-up outpatient visits or for out-of-area follow-up care that involves a surgical or other procedure or inpatient stay.

Dental Coverage

Customize your plan with affordable dental coverage.

Monthly Dental Coverage Rates		
	Dental PPO	Dental HMO
Individual (Adult or YouthCare)	\$34	\$16
Two-Party	\$65	\$30
Family	\$101	\$50

* **Please Note:** Monthly dues for the Dental HMO and Dental PPO plans are in addition to the dues/premiums for medical benefits covered by the Blue Shield health plan. However, you will receive one bill that combines your health, dental and, if applicable, life insurance premiums. If you select the Dental HMO, your health plan and dental coverage effective dates must be the first of the month. (No benefits are paid for services received before effective date.)

Dental Coverage

Because dental health is an important part of total wellness, we offer you several affordable dental coverage options. All applicants who qualify for a Blue Shield health plan may choose between the Blue Shield Dental PPO Plan and the Blue Shield Dental HMO Plan for quality dental coverage at affordable rates.

The Blue Shield Dental PPO Plan

With the Blue Shield Dental PPO Plan, you have the freedom to choose any dental provider, but your out-of-pocket costs for covered services are lowest when you receive care from Participating Dentists. The Dental PPO Plan features:

- An extensive network of general care and specialty dentists.
- An individual deductible of \$50 per member per calendar year.
- A wide range of dental benefits, including diagnostic and preventive services at no out-of-pocket cost.
- Coverage even when you use an out-of-network dentist – the plan reimburses you for up to a specified amount, and you pay the balance of the total billed charges.
- A \$1,000 per-member per-year benefit maximum – including a \$500 per-member per-year maximum for out-

of-network benefits. (Each calendar year, the member is responsible for all charges incurred after the plan has paid these amounts for covered dental services.)

- No waiting period for diagnostic or preventive services. The following waiting periods do apply: Three months for minor restorative services and procedures (such as fillings), endodontics, periodontics, and oral surgery. Twelve months for major restorative services and procedures (such as crowns), orthodontics, removable and fixed prosthetics.

The Blue Shield Dental HMO Plan

With the Blue Shield Dental HMO Plan, you choose a dental care location from our list of Blue Shield Dental HMO Dental Centers. All of your family's dental care will be provided or coordinated through that Dental Center. The Dental HMO Plan features:

- An extensive network of general care and specialty dentists.
- No deductibles or calendar-year maximums.
- A wide range of dental benefits, including most diagnostic and preventive services at no out-of-pocket cost to you, and generally lower copayments than the Dental PPO.
- Specialty care available with a referral from your Dental Center.

- No waiting period for any type of service other than orthodontics. (A 12-month waiting period applies to orthodontic services.)
- No claim forms.

Access+ *Dentist* – For Access+ HMO members only

Access+ HMO members have built-in dental benefits through Access+ *Dentist*, with no additional dues. Just show your Blue Shield ID card when you visit an Access+ *Dentist* provider, and you'll receive dental services at reduced out-of-pocket costs, including diagnostic and preventive services for \$20 copayments. See the column titled "Access+ *Dentist*" on the Dental Highlights Matrix. Although Access+ *Dentist* is included in the health plan, Access+ HMO members can choose to purchase a more generous dental plan instead of receiving the Access+ *Dentist* benefits.

It's easy to enroll!

To apply for the Blue Shield Dental PPO or Dental HMO Plan, all you need to do is mark your selection on the health plan application. If your health plan application is approved, your dental coverage will take effect on the same day as your health plan. You and any dependents covered on your Blue Shield health plan will be covered by the dental plan you choose. YouthCare applicants may be covered on their own dental plan.

If you are signing up for the Blue Shield Dental HMO, please be sure to list a Dental Center for yourself and your family on your application. If you do not have a copy of Blue Shield's *Dental HMO Dental Center Directory*, please visit the Find a Provider section of our Web site at www.mylifepath.com or call (800) 431-2809.

Dental PPO and Dental HMO Highlights Matrix

This chart is only a summary. For a complete list of the benefits, exclusions and limitations of the Dental PPO or Dental HMO, please refer to the Supplement to the Service Agreement/Policy for your health plan. For a complete description of the Access+ *Dentist* feature, please see the Access+ HMO Service Agreement. We will automatically send you a copy of the applicable Supplement when your health plan application is approved. To have a Supplement sent sooner, please call (800) 431-2809.

SERVICE	DENTAL PPO ^{1,2}		DENTAL HMO ^{3,4}	ACCESS+ <i>DENTIST</i>
	With Participating Dentists, you pay:	With Non-Participating Dentists, the plan reimburses you up to:	You pay:	(Access+ HMO members only) ⁵ You pay:
Diagnostic Services				
Comprehensive oral exams	\$0	\$40	\$0	\$20 (Plus \$10 for full-mouth series X-rays)
Preventive Care				
Prophylaxis (cleanings, every 6 months)				
Adult	\$0	\$48	\$0	\$20
Child	\$0	\$34	\$0	\$20
Sealant/per tooth ⁶ (covered to age 16)	\$0	\$22	\$11	\$10
Restorative Services²				
One-surface amalgam (filling)	\$35	\$28	\$15	80%**
Crown (porcelain fused to noble metal)	\$320	\$256	\$300*	80%**
Endodontics²				
Anterior root canal	\$156	\$125	\$155	80%**
Molar root canal	\$234	\$187	\$290	Not Covered
Periodontics²				
Osseous surgery/per quadrant	\$263	\$210	\$303	Not covered
Periodontal root planing/per quadrant	\$65	\$52	\$75	80%**
Prosthetics²				
Bridge (per unit)	\$320	\$256	\$300*	80%**
Complete denture (upper or lower)	\$388	\$310	\$400	80%**
Oral Surgery²				
Extraction (single tooth)	\$37	\$30	\$30	80%**
Removal of impacted tooth (complete bony)	\$113	\$90	\$125	Not Covered
Orthodontics^{2,4,7}				
Fully banded (two year) case – child	\$2350***	Not Covered	\$2350***	Not Covered
Fully banded (two year) case – adult	\$2650***	Not Covered	\$2650***	Not Covered

1 Use any Participating Dentist to take advantage of contracted rates and pay lower out-of-pocket costs. When you use dentists who are not in our network, the plan reimburses up to the amount listed and you are responsible for all charges in excess of that amount and a \$50 calendar-year deductible.

2 Dental PPO members have certain waiting periods: three months for minor restorative services and procedures (such as fillings), endodontics, periodontics and oral surgery; twelve months for major restorative services and

procedures (such as crowns), orthodontics and removable and fixed prosthetics.

3 All services must be performed, prescribed or authorized by your Dental Center, chosen from the Blue Shield Dental HMO Dental Center Directory. If you need to see a specialist, you must get a referral from your Dental Center to receive covered services.

4 Dental HMO members have a 12-month waiting period for orthodontics. (There are no waiting periods for other covered services.)

5 Benefits available only when you use Access+ *Dentist*. (Access+ *Dentists* are listed in the Blue Shield Directory of Access+ *Dentists*.)

6 Coverage for sealants is limited to the first and second permanent molars.

7 Orthodontic services are a fixed patient copayment and do not apply to your \$1,000 in-network Plan Maximum.

* Plus the cost of precious or semi-precious metals.

** Based on the attending dentist's billed charges.

*** Plus up to \$250 for records.

Individual Term Life Insurance

If you'd like to add the financial protection and security of \$10,000, \$30,000, \$60,000 or \$90,000 in term life insurance to your coverage portfolio, Blue Shield of California Life & Health Insurance Company offers a simple solution. Applying for term life coverage couldn't be easier. Just complete the life insurance part of your Blue Shield health plan application by checking the box for the amount of life insurance coverage you want, and designate your beneficiary. If coverage is approved, your health plan and life insurance effective dates will be the same, and you'll receive a single combined bill.

Individual term life insurance is available to primary subscribers (ages 1 through 64) of any Blue Shield health plan for individuals and families, including YouthCare subscribers. Members of Blue Shield Guaranteed Issue plans are not eligible. Individual term life insurance is available only to primary applicants and YouthCare applicants.

Health Savings Account

Important Information Regarding Health Savings Accounts

Blue Shield has designed the PPO Savings Plan (2400/4800) to meet government requirements for a high-deductible health plan, which would permit qualified individuals to open tax-advantaged Health Savings Accounts (HSAs). If you are eligible, it may allow you to take advantage of the income tax benefits available when you establish an HSA and use the money you put into the HSA to pay for qualified medical expenses subject to the deductibles under this plan.

NOTICE: Blue Shield does not currently have a relationship with an HSA Administrator or provide tax advice. If you intend to

MONTHLY INDIVIDUAL TERM LIFE INSURANCE PREMIUMS

Age Range	Amount of Insurance			
	\$10,000	\$30,000	\$60,000	\$90,000
1-18	1.95	2.95	N/a*	N/a*
19-29	2.75	5.35	9.25	13.15
30-39	3.05	6.25	11.05	15.85
40-49	5.85	14.65	27.85	41.05
50-59	13.85	38.65	75.85	113.05**
60-64	20.45	58.45	115.45	172.45**

* Those under age 19 are not eligible for \$60,000 and \$90,000 life insurance options.

** \$90,000 benefit amount is not available for new sales to those age 50 years or older, but current members with in-force policies who turn age 50 are eligible to keep their coverage until age 65.

If you choose to apply for individual term life insurance after you are approved for a Blue Shield health plan, you must request a Blue Shield Life Evidence of Good Health form by calling Blue Shield at **(800) 431-2809** or download it from bscalife.com. If coverage is approved,

your life insurance effective date will be the first day of the month following approval.

Please Note: Individual term life insurance is underwritten by the Blue Shield of California Life & Health Insurance Company.

purchase this plan to use with an HSA for tax purposes, you should consult with your tax advisor about whether you are eligible and whether your HSA meets all legal requirements. The HSA is a governmental pilot program that is continued year to year at the discretion of Congress.

Although Blue Shield believes that the plan meets these requirements, the Internal Revenue Service has not ruled on whether the plan is qualified as a high-deductible health plan. Should you purchase this plan to obtain the income tax benefits associated with an HSA and the Internal Revenue Service were to rule that this plan does not qualify as a high-deductible health plan, you

may not be eligible for the income tax benefits associated with an HSA. In this instance, you may have adverse income tax consequences with respect to your HSA for all years in which you were not eligible. However, if there were such a ruling, or if government requirements for a high-deductible health plan change, Blue Shield intends to amend the Shield Spectrum PPO Savings Plan prospectively, if necessary, to meet the requirements of a qualified plan. A change in the plan's dues may also be required as a result of a change in the plan.



Accessing Your Plan Benefits

This section explains how to correctly access benefits with any Blue Shield plan for individuals and families. You'll find general information that applies across all plans on the "All Blue Shield Health Plans" pages. Additional information specific to HMO and PPO health and dental plans appears on subsequent pages.

Definitions of many terms may be found in the Glossary on page 43. For a complete description of any plan, please contact us to request the plan's *Evidence of Coverage and Health Service Agreement (EOC)* or *Certificate of Insurance and Policy (COI)*.

Using All Blue Shield Health Plans

Prepayment Fees

The monthly dues/premiums for each plan are shown in the brochure *Monthly Rates for Individuals and Families*. The dues/premiums for each plan are subject to change following at least 30 days written notice by Blue Shield to you.

Accessing Mental Health and Substance Abuse Services

Blue Shield has contracted with a specialized health care service plan to act as our Mental Health Services Administrator (MHSA). Mental health and substance abuse services are delivered to Blue Shield members through this network of MHSA participating providers.

The MHSA must provide prior authorization for all inpatient mental health services, except for Emergency Services, in order for them to be covered by your plan.

Obtaining Emergency Services – anywhere in the world

With all Blue Shield plans, emergency services are covered anywhere in the world. A true emergency is defined as an unexpected medical condition, including a psychiatric emergency medical condition, sudden trauma or illness so severe that without immediate medical attention any of the following are true:

- your life or health may be in serious jeopardy;

- there may be serious harm to your bodily functions; or
- there may be serious harm to your organs or body parts.

For example, suffering a stroke or breaking a leg are emergency situations.

Obtaining Urgent Care away from home – The BlueCard Program

There are specific guidelines you can follow to obtain care when you are away from home. Please read the Service Agreement for a complete explanation. More than 85 percent of all hospitals and physicians throughout the United States participate in the BlueCard Program.

Blue Shield Facilities

Our provider directories are updated periodically to reflect changes in our provider networks. Check our online directories for our most up-to-date listings, in the Find a Provider section of www.mylifepath.com. Request a Blue Shield directory from your Blue Shield agent, or by calling Member Services at (800) 431-2809.

Enrolling New Dependents

Newborn infants and children placed with the subscriber for adoption will automatically receive inpatient care/delivery coverage on your plan for a 31-day grace period starting the moment of birth or the date you or your spouse gain the right to control the adopted child's health care. If dues/

premiums aren't received, all other services will be denied. You must officially add the child to your plan to continue coverage. A new spouse may be added to your Service Agreement/Policy at any time, as soon as his or her application is approved and dues/premiums are paid. Call Member Services at (800) 431-2809 to add a newborn, and/or spouse to your plan.

Copayment Maximum and Out-of-Pocket Maximum guidelines

Access+ HMO and the Shield Spectrum PPO Savings Plans include out-of-pocket maximums to limit the total amount you might have to pay for certain medical expenses in a calendar year. Shield Spectrum PPO Plans and the Active Choice Plan include a copayment maximum amount to limit the total amount you might have to pay for certain medical expenses in a calendar year. Copayments for some services do not count towards the copayment maximum or out-of-pocket maximum and continue to apply after the maximum amount has been met.

If you reach a calendar-year copayment maximum or out-of-pocket maximum for any plan, Blue Shield will start to pay 100 percent of the allowable amount for all the applicable covered services you receive through the remainder of the calendar year, up to specified benefit maximums. The lifetime maximum for Active Choice and Shield Spectrum PPO plan members is

\$6,000,000 per person, and there is no lifetime maximum for Access+ HMO members.

Utilization Review Process

State law requires that health plans disclose to plan members and health plan providers the process used to authorize or deny healthcare services under the plan. Blue Shield has documented its Utilization Review process. Please see your EOC/COI, or you can call Member Services at **(800) 424-6521** (for plans underwritten by Blue Shield of California) or **(800) 200-3242** (for plans underwritten by Blue Shield of California Life & Health Insurance Company) to request a copy.

Prior Authorization of Selected Drugs

Selected drugs and drug dosages require prior authorization by Blue Shield for medical necessity, appropriateness of therapy or cost effectiveness. Your physician may request prior authorization from Blue Shield Pharmacy Services.

Renewal Provisions

Your Blue Shield health coverage is “guaranteed renewable” (it may not be canceled by Blue Shield) and will remain in effect as long as your dues/premiums are paid in advance – except under the conditions listed in the “Termination of Benefits” section below. Blue Shield may modify or amend the Service Agreement/Policy or dues/premium amount by giving you at least 30 days prior written notice.

Termination of Benefits

Termination of Plan Type

For any Blue Shield health plan, Blue Shield may terminate a subscriber’s EOC/COI together with all like EOC/COIs by giving 90 days written notice. Blue Shield may also terminate the subscriber’s EOC/COI for

cause immediately or upon 30 days written notice. No Blue Shield plan coverage will be terminated or rescinded individually by Blue Shield for any cause except those outlined in the EOC/COI. They include:

- Nonpayment of dues/premiums (if you are hospitalized or undergoing treatment for an ongoing condition and your plan is cancelled, you will no longer receive benefits of the plan)
- Fraud or misrepresentation
- Subscriber moves out of California
- Association membership ends
- Repeated failures to establish a satisfactory relationship with a Personal Physician
- If a member fails or refuses to provide access to documents and other information that was requested in the application for coverage.

Continuity of Care by a Terminated Provider

Members who are being treated for acute conditions, serious chronic conditions, pregnancies or terminal illness; or who are children from birth to 36 months of age; or who have received authorization from a now-terminated provider for surgery or another procedure as part of a documented course of treatment can request completion of care in certain situations with a provider who is leaving the Blue Shield of California or Blue Shield Life provider network by calling **(800) 431-2809**.

Financial Responsibility for Continuity of Care Services

For PPO Plan members who are entitled to receive services from a terminated provider under the Continuity of Care provision, the responsibility of the member to that provider for services rendered under that provision shall be no greater than for the same services rendered by a Preferred Provider in the same geographic area.

Grievance Process

Blue Shield of California and Blue Shield of California Life & Health Insurance Company have established a grievance procedure for receiving, resolving and tracking members’ grievances with Blue Shield. For more information on this process, see the “Grievance Process” section in the plan’s EOC/COI.

External Independent Medical Review

State law requires Blue Shield to disclose to members the availability of an external independent review process when a member’s grievance involves a claim or services for which coverage was denied by Blue Shield or by a contracting provider in whole or in part on the grounds that the service is not medically necessary or is experimental/investigational. For Access+ HMO, Shield Spectrum PPO Plans (except PPO Plan 5000), Shield Spectrum PPO Savings Plans and Dental Plans: You may choose to make a request to the Department of Managed Health Care to have the matter submitted to an independent agency for external review in accordance with California law. If you are enrolled in Active Choice or PPO Plan 5000, you may request independent review through the California Department of Insurance.

Department of Managed Health Care Review

This information is relevant to all plans underwritten by Blue Shield of California: The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan and use your health plan’s grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or

remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number, (888) HMO-2219, and a TDD line,

(877) 688-9891, for the hearing and speech impaired. The department's Internet Web site <http://www.hmohelp.ca.gov> has complaint forms, IMR application forms and instructions online.

Department of Insurance

This information is relevant for all plans underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life): The California Department of Insurance is responsible for regulating health insurance. The Department's Consumer Affairs Division has a toll-free number, (800) 927-4357, to receive complaints regarding health insurance. If you have a complaint or grievance against Blue Shield

Life, you should contact Blue Shield Life first and use their grievance process. If you need the Department of Insurance's help with a complaint or a grievance that has not been satisfactorily resolved by Blue Shield Life, you may call the Department's toll-free telephone number.

Medical Necessity Exclusion

All services must be medically necessary. The fact that a physician, hospital or other provider prescribes, orders, recommends or approves a service or supply does not, in itself, make it medically necessary, even if it is not specifically listed as a plan exclusion or limitation. Blue Shield may limit or exclude benefits for services that are not medically necessary.

Using Your Access+ HMO Plan

This section provides additional information that is specific only to Access+ HMO. Please refer to the previous section, "Using All Blue Shield Plans," for general information that applies to all plans.

Obtaining Specialty Care with the Access+ HMO plan

Option 1: Referral to Specialty Services and Second Opinions

There are conditions under which you may ask your Personal Physician to refer you to another physician for a second opinion. All second opinion consultations must be authorized by the plan. State law requires that health plans disclose to members, upon request, the timelines for responding to a request for a second medical opinion. Submit requests to (800) 424-6521.

Option 2: Use your Access+ Specialist feature

Access+ Specialist allows you to go to any participating specialist or Personal Physician in the same medical group or

IPA as your Personal Physician without a referral, by paying a \$30 copayment. This benefit is subject to the limitations described in the EOC.

Pregnancy and Maternity Care

Pregnancy is a Waivered Condition. Benefits for a Waivered Condition are not covered during the six (6)-month period beginning as of the effective date of coverage, with the exception of services required to treat involuntary complications of pregnancy. However, if you have prior creditable coverage, and you apply for coverage within 63 days after termination of the prior coverage, Blue Shield will credit the length of time you were covered on your previous health plan toward the six-month period.

Accessing Mental Health and Substance Abuse Services

The Access+ Specialist feature is also available for mental health and substance abuse services, as long as the Provider is an MHSA participating provider. Refer to the Blue Shield of California Behavioral Health Provider Directory, or call the MHSA directly at (877) 263-8827 to determine the MHSA participating providers.

Non-emergency mental health services and substance abuse services received from a provider who is not in the MHSA participating provider network will not be covered, and all charges for these services will be the member's responsibility.

Accessing Emergency Care

If you believe that you have a medical condition which requires an emergency response, you are encouraged to use the 911 emergency response system where available.

If you obtain emergency services, you should notify your Personal Physician within 24 hours after care is received unless it was not reasonably possible to communicate with the Personal Physician within the time limit. In such case, notice should be given as soon as possible.

Please Note: If you receive non-authorized services in a situation that Blue Shield determines was not a situation in which a reasonable person would believe that an emergency condition existed, you will be responsible for the costs of those services.

Obtaining Urgent Care close to home

When you are within your Personal Physician's service area, contact your Personal Physician to receive urgent care. This care must be provided or arranged by your Personal Physician except when you use the Access+ *Specialist* feature.

Obtaining Urgent Care away from home

There are specific guidelines you can follow to obtain care when you are away from home. Please read the EOC for a complete explanation.

Liability of Subscriber or Enrollee for Payment

For most covered services, members pay a fixed dollar copayment. Some services are covered at no charge to the member. The member will be responsible for payment of services that are not authorized by the

Personal Physician or those that are not emergency or covered out-of-area urgent service procedures.

If your condition requires services that are available from the plan, payment for services rendered by non-network providers will not be considered unless the medical condition requires emergency or urgent services.

Enrolling New Dependents

Newborn infants and children placed with the subscriber for adoption will automatically be covered on your plan for a 31-day grace period starting the moment of birth or the date you or your spouse gain the right to control the adopted child's health care. With the Access+ HMO plan, the child's services must be provided or authorized by his or her Personal Physician. For the month following birth or adoption, you must choose a Personal Physician from the same medical group or IPA as the mother's Personal Physician. (If the mother is not an Access+ HMO member or if the child has been placed with the subscriber for adoption, you must select a Personal Physician in the same medical group or IPA as the subscriber's Personal Physician.) Please note that eligibility during the 31-day grace period includes treatment for injury or illness only but does not include well-baby care benefits unless the child is enrolled. **Well-baby care benefits are provided for enrolled children.** Call Member Services at (800) 431-2809 to add a newborn to your plan.

Choice of physicians and providers

Please read the following information so you will know which providers to access.

Access+ HMO offers you a choice of physicians, hospitals and non-physician

healthcare practitioners. With Access+ HMO, you will be able to select your own Personal Physician from the Blue Shield HMO network of providers.

The Find a Provider section of our Web site, www.mylifepath.com, and our HMO Physician and Hospital Directory list the locations and phone numbers of all Personal Physicians in your area, as well as the medical group or IPA with which they're affiliated. Each of your eligible family members may select a different Personal Physician, as long as each provider is located adequately close to the member's home or work address to ensure adequate access to care as determined by Blue Shield. Please note that plan hospitals can be **Choice** or **Affiliate** providers, and different copayments may apply.

Reimbursement Provisions

If emergency services were received and expenses were incurred by the member for services other than medical transportation, the member must submit a complete claim with the emergency service record for payment to the plan within one year after the first provision of emergency services for which payment is requested. In the event covered medical transportation services are obtained in such an emergency situation, the Blue Shield Access+ HMO shall pay the medical transportation provider directly. If out-of-area urgent services were received from a provider who is not in the BlueCard network, the member must submit a complete claim with the urgent service record for payment to the plan within one year after the first provision of urgent services for which payment is requested.

Using All Blue Shield PPO Plans

This section provides additional information that is specific only to Blue Shield PPO plans. Please refer to the section titled “Using All Blue Shield Health Plans” for general information that applies to all plans.

Choice of physicians and providers

Blue Shield PPO plans allow you to choose a preferred or non-preferred (non-network) provider each time you access care. However, our PPO plans are specifically designed for you to use Blue Shield preferred providers. They are listed in the Blue Shield preferred provider directories or online in the Find a Provider section of www.mylifepath.com. Preferred hospitals can be **Choice** or **Affiliate**, and different copayments may apply.

Liability of Subscriber or Enrollee for Payment

Preferred providers

Preferred providers agree to accept Blue Shield’s payment, plus your payment of any applicable deductible and copayment, or amounts in excess of benefit dollar maximums specified, as payment-in-full for covered services.

Non-preferred providers

Blue Shield’s payment for non-preferred (non-network) providers may be substantially less than the amount billed. You are responsible for the difference between the amount Blue Shield pays and the amount billed by non-preferred providers. In some instances, services are covered only if rendered by a preferred provider. Using a non-preferred provider could result in lower or no payment by Blue Shield for these services.

If emergency care is needed in a non-preferred hospital, payment will be made at the hospital’s billed charge for covered services, less any applicable deductible or copayment.

Accessing Mental Health and Substance Abuse Services

MHSA participating providers agree to accept the MHSA’s payment, plus your payment of any applicable deductible and copayment, or amounts in excess of benefit dollar maximums specified, as payment-in-full for covered mental health and substance abuse services. To find an MHSA participating provider, refer to the Blue Shield of California Behavioral Health Provider Directory, or call toll-free **(877) 263-7178**

Accessing Emergency Care

In an emergency, seek care at the nearest medical facility. If possible, call your regular physician for instructions first. You or a family member must notify Blue Shield within 24 hours of receiving inpatient emergency care, or by the end of the first business day following treatment. If Blue Shield determines that your situation was not a true emergency, your copayment responsibility will be determined according to whether you used a preferred or non-preferred provider or hospital.

Obtaining Urgent Care close to home

In an urgent medical situation, call your regular doctor if possible. You can also visit a PPO network urgent care center near you. In using one of these clinics, you will pay the non-emergency copayment. After you meet any applicable plan deductible, urgent care will be covered similar to other non-emergency covered services. Your copayment responsibility will depend on whether you see a preferred or non-preferred provider.

How a Plan Deductible works

With a calendar-year deductible, you will pay 100 percent of the costs for services that are “subject to the deductible,” until you meet the deductible.

The full amount you pay – up to the **allowable amount** for that service – will count toward your deductible. Once you meet a plan deductible, you will become eligible for all your plan’s benefits and will start to pay the applicable copayments for covered services.

With any PPO plan, some covered services are never subject to any plan deductible, so you can receive benefits for these medical services right away, including preventive care.

Reimbursement Provisions

When you use preferred providers, you generally won’t have to pay for services at the time of your visit. Most preferred providers will bill Blue Shield directly, and then bill you for your payment responsibility. Blue Shield will apply the appropriate amount toward any applicable deductible.

When you use non-preferred providers, you must pay the provider directly for the entire cost of your care, either at the time of your visit or upon billing afterwards. Once you receive the bill, simply submit a copy of it with a claim form to Blue Shield. We will apply the appropriate amount to your plan deductible, or reimburse you for the applicable percentage of the Blue Shield allowable amount if you’ve already met your plan deductible.

Pre-existing Conditions

Benefits for pre-existing conditions will not be available until six months after Blue Shield receives your application. However, if you have “prior creditable coverage,” and you apply for coverage within 63 days after termination of the prior creditable coverage, Blue Shield will credit the length of time you were covered on your previous health plan toward the six-month waiting period.

This exclusion does not apply to subscribers enrolled in the Shield Spectrum PPO Plan 1500 or 2000, or Shield Spectrum PPO Plan 1500 (BSL) and 2000 (BSL) under “Guaranteed Issue,” or to newborn or adopted children who:

- were enrolled under any creditable coverage within 31 days of the birth, adoption or placement for adoption; and
- applied for this plan within 63 days of termination of the creditable coverage.

Guaranteed Issue Coverage

Blue Shield’s guaranteed issue coverage is provided as an alternative for people who may not be eligible for underwritten plans because of a pre-existing condition. Please see the health plan application for details on who qualifies for “Guaranteed Issue.”

The PPO Plans Benefits Management Program

All Blue Shield PPO plans include a Benefits Management Program to help you and your physician identify the most appropriate and cost-effective medical treatments for which you may receive benefits. In this way, the Benefits Management Program will help you control your healthcare coverage costs. If you do not contact Blue Shield before obtaining certain services, you may be responsible for additional payment or reduced payment requirements, or this may also result in non-payment if the service is determined not to be a covered service.



Using Your Blue Shield Dental Plan

Conditions of Coverage

Dental PPO and Dental HMO plan benefits are separate from the medical benefits of the Blue Shield health plans. General plan provisions and exclusions apply with the exception of the following:

- Dental PPO and Dental HMO benefits are not subject to the health plan deductible requirements and do not accumulate toward the maximum calendar-year copayment responsibility.
- The provisions of *Access+ Satisfaction* shall not apply to any dental services.
- In-network benefits of the Blue Shield Dental PPO, the Blue Shield Dental HMO and *Access+ Dentist* will be underwritten and administered by “the Dental Plan Administrator,” Dental Benefit Providers of California, Inc. Dental PPO out-of-network benefits will be underwritten by Blue Shield and administered by the Dental Plan Administrator.

- If your dental coverage is canceled for any reason (by you or by Blue Shield), you may apply for reinstatement, but your coverage (if approved) will be subject to a waiting period of 12 months from the cancellation date.

Dental Member Services

If you have a question about dental services, providers, your dental benefits or how to use your dental plan, or concerns regarding the quality of care or access to care that you have experienced, you may call your Dental Member Services Department at **(888) 679-8928**. Dental Member Services can answer many questions over the telephone.

Grievance Process

For more information on this process, see the grievance process section in the dental plan Service Agreement.

Principal Benefits and Coverages

Please see the Uniform Matrices for each plan's covered services and supplies. Also, refer to the EOC/COI, which you will receive after you enroll. These materials offer more detailed information on the benefits and coverage included in your health plan.

Principal Exclusions and Limitations on Benefits for all Blue Shield health plans for individuals and families

For complete detail on any plan's exclusions and limitations, please read the EOC/COI. Unless exceptions to the following exclusions are specifically made in the EOC/COI for your plan, no benefits are provided for medical services or procedures that are:

- Experimental or investigational in nature;
- For or incident to services rendered in the home, or for or incident to hospitalization or confinement in a health facility primarily for custodial, maintenance or domiciliary care, rest, or to control or change your environment, or to treat eating disorders such as bulimia, anorexia, etc.;
- Performed in a hospital by hospital officers, residents, interns or others in training;
- For cosmetic surgery or any resulting complications, except that benefits may be provided for medically necessary services to treat complications of cosmetic surgery (e.g., infections or hemorrhages) upon review and approval by a Blue Shield physician consultant;
- Incident to an organ transplant;
- For convenience items such as telephones, TVs, guest trays and personal hygiene items;
- For contraceptives and contraceptive devices except as specifically included in the Family Planning Services benefit and under the Outpatient Prescription Drug benefit;

- For or incident to speech therapy, speech correction or speech pathology; speech services for or incident to speech abnormalities that are not likely the result of a diagnosed, identifiable medical condition injury or illness except as specified in the EOC/COI;
- For or incident to intersex surgery (transsexual operations) except for medically necessary treatment of medical complications;
- For penile implant devices and surgery, and any related services;
- For routine foot care including callus removal, corn paring or excision, toenail trimming, and treatment (other than surgery) of chronic conditions of the foot (e.g., weak or fallen arches, flat or pronated foot, pain or cramp of the foot, bunions, muscle trauma due to exertion or any type of massage procedure on the foot), and for special footwear;
- For or incident to dental care and dental supplies including but not limited to diagnostic, preventive, periodontic and orthodontic services; dental implants; braces, crowns, dental orthoses and prostheses;
- For substance abuse, or substance abuse treatment or rehabilitation on an inpatient, day-care or outpatient basis except as specifically defined under the Mental Health and Substance Abuse Services section in the EOC/COI;
- For learning disabilities or behavioral problems;
- For or incident to acupuncture;
- For conditions covered by Workers' Compensation or similar laws;
- Performed by a close relative or by a person who ordinarily resides in the subscriber's or dependent's home;
- For or incident to vocational, reading, educational, recreational, art, dance or music therapy, weight control or exercise programs;

Conditions for Coverage

No person has the right to receive the benefits of any Blue Shield health plan for services provided following termination of coverage. Benefits of this plan are available only for services provided during the term the plan is in effect, and while the individual claiming benefits is actually covered by the plan EOC/COI. Benefits may be modified during the term of the plan EOC/COI or upon renewal. If benefits are modified, the revised benefits (including any reduction in benefits or the elimination of benefits) apply for services provided on or after the effective date of the modification. There is no vested right to receive the benefits of any Blue Shield plan as outlined in the EOC/COI.

- For eye refractions, surgery to correct refractive error (such as but not limited to radial keratotomy, refractive keratoplasty), lenses and frames for eye glasses or contact lenses;
- For hearing aids;
- In connection with private duty nursing;
- For prescribed drugs and medicines for outpatient care;
- For over-the-counter medications not requiring a prescription;
- For infertility services, including professional, hospital, ambulatory surgery center, ancillary services and drugs to diagnose and treat causes of infertility; in vitro fertilization, Gamete Intrafallopian Transfer (G.I.F.T.) procedure or any other induced fertilization, artificial insemination, or services incident to or provided for a surrogate mother who is not a Blue Shield health plan member eligible for maternity benefits;
- For physical exams required for licensure, employment, or insurance unless the examination corresponds to the schedule of routine physical examinations specifically provided in the EOC/COI; or for immunizations for the purpose of travel;

- For dental care or services incident to the treatment, prevention or relief of pain or dysfunction of the temporomandibular joint and/or muscles of mastication;
 - For home testing devices and monitoring equipment;
 - For or incident to sexual dysfunction or sexual inadequacies, except as provided for treatment of organically based conditions;
 - For or incident to out-of-country services, except for urgent or emergency services as specified in the EOC/COI;
 - For reconstructive surgery or procedures except as specified in the EOC/COI;
 - For which you are not legally obligated to pay or for services for which you are not charged;
 - For genetic testing, except as specified in the EOC/COI; or
 - Not specifically listed as a benefit in the EOC/COI.
- For rehabilitation, unless pre-approved in accordance with the Benefits Management Program, when services are the result of the conditions specified in EOC/COI;
 - For any procedure (e.g., vestibuloplasty) intended to prepare the mouth for dentures or for the more comfortable use of dentures;
 - For or related to hospitalization primarily for X-ray, routine screening laboratory or any other studies or medical observation;
 - For prescription and non-prescription food and nutritional supplements; or
 - For Pap tests or other approved cervical cancer screening tests, mammography and colon cancer screening, health appraisals, vision and hearing tests, physical examinations and immunizations. Benefits for these services are only provided as specifically defined under the Preventive Care section of the EOC/COI.
- For disposable medical supplies as specified in the Exclusions and Limitations section of the EOC/COI;
 - For hearing aids;
 - For transportation services other than the ambulance benefit specifically provided in the EOC/COI;
 - For any type of communicator, voice enhancer, voice prosthesis or other language assistance device, except that a Blumsinger prosthesis for speech may be covered following a laryngectomy;
 - For speech therapy, speech correction or speech pathology;
 - For or incident to hospitalization or confinement in a pain management center to treat or cure chronic pain, except as medically necessary;
 - For or incident to reversal of a vasectomy or tubal ligation, or repeat vasectomy or tubal ligation;
 - Unauthorized non-emergency services;
 - For premarital blood tests; or
 - For testing for intelligence or learning disabilities.

Also Excluded for Blue Shield PPO plans (Active Choice Plan 600, Shield Spectrum PPO Plans, Shield Spectrum PPO Savings Plans)

- Services for or incident to the reversal of surgical sterilization;
 - To provide orthopedic shoes, other supportive devices for the feet, air conditioners, humidifiers, dehumidifiers, air purifiers, exercise equipment, generators or any other equipment not primarily medical in nature, including but not limited to spas, saunas and sun lamps;
 - For or incident to hospitalization or confinement in a health facility primarily to treat or cure chronic pain, except for those benefits which would have been provided on an outpatient basis anyway (for example, charges for room and board are not a benefit unless medically necessary);
 - For outpatient mental health and substance abuse services;
- ### Also Excluded for Access+ HMO plan
- Services not provided, prescribed, referred or authorized by your Personal Physician or Blue Shield, except for (a) emergency or urgent services as specifically provided under the plan; (b) Access+ *Specialist* services; (c) OB/GYN services received from an OB/GYN or family practice physician in your Personal Physician's medical group or IPA; or (d) when specific authorization has been obtained in writing from Blue Shield;
 - For spinal manipulation or adjustment;
 - For rehabilitation services in excess of those specified in the EOC/COI, or when services are the result of the conditions specified in the EOC/COI;
 - For orthopedic shoes, environmental control equipment, exercise equipment, self-help or educational devices, generators, comfort items, vitamins or prescription or non-prescription food and nutritional supplements;

Outpatient Prescription Drug Exclusions for Active Choice, Shield Spectrum PPO Plans and Access+ HMO plans

- Drugs obtained from a non-participating (non-network) pharmacy, except for covered emergency care, including emergency contraceptives;
- Drugs received from a hospital, convalescent home, skilled nursing facility or similar facility that are taken home;
- Injectable drugs which are not self-administered in the home, including all injectable drugs for the treatment of infertility;
- Any drug provided or administered while the member is an inpatient, or in a physician's office;

General Exclusions and Limitations for All Blue Shield Dental Plans for Individuals and Families

- Drugs prescribed for cosmetic purposes, including but not limited to drugs used to retard or reverse the effects of skin aging or to treat hair loss;
- Dietary or nutritional products;
- Appetite suppressants and other weight loss medications;
- Drugs when prescribed for smoking cessation purposes;
- Contraceptive devices (except diaphragms), injections and implants;
- Except as specifically listed as covered in the EOC/COI, drugs which can be obtained without a prescription or have a non-prescription (over-the-counter) therapeutic equivalent;
- Drugs for which the member is not legally obligated to pay, or for which no charge is made;
- Drugs that are considered to be experimental or investigational;
- Medical devices or supplies, except as specifically listed as covered in the EOC/COI;
- Blood or blood products except as specified in the Hospital Benefits section of the EOC/COI;
- Injectable drugs for the treatment of infertility are not covered;
- Compounded medications if: (1) there is a medically appropriate formulary alternative or (2) there are no FDA-approved indications (compounded medications that do not include at least one drug, as defined, are not covered);
- Replacement of lost, stolen or destroyed prescription drugs;
- Drugs for treatment of dental conditions except antibiotics prescribed to treat infection or medications prescribed to treat pain;
- Non-formulary drugs, except with prior authorization from Blue Shield as described in the EOC (Access+ HMO only).

Dental Coverage General Exclusions and Limitations

Following is a summary of services and supplies not covered by the Blue Shield Dental PPO and Dental HMO. For a complete list of dental coverage exclusions and limitations, please refer to the plans' Service Agreement/Policy Supplements.

Dental PPO, Dental HMO and Access+ Dentist

- Services not listed as covered in the member's Service Agreement Dental Supplement;
- Services to be paid by the member's Blue Shield health plan;
- Services begun prior to the patient's effective date of coverage;
- Temporary dental services;
- Services performed or supplies provided in a hospital or any place other than a dental office;
- Unnecessary, investigational, experimental, cosmetic or elective services; services for which the prognosis is not favorable, as determined by the Dental Plan Administrator;
- Services performed by a close relative or someone who lives in the member's home; services for which the member is not obligated to pay or services performed at no charge;
- Services paid for by any governmental agency;
- Implants;
- Crowns, inlays, onlays or other cast or laboratory-prepared materials if the tooth can be restored with a filling material; crowns or inlays installed as multiple abutments;
- Vestibuloplasty, orthognathic surgery, treatment of jaw fractures or TMJ (temporomandibular joint) syndrome;
- Treatment of congenital anomalies or developmental malformation;
- Treatment to correct malignancies, cysts, tumors and neoplasm;
- Myofunctional therapy, biofeedback procedures, athletic mouth guards, precision or semi-precision attachments, denture duplication;
- Orthodontic services rendered by a non-participating provider;
- Extraoral grafts;
- Procedures related to changing or maintaining vertical dimension or restoration of occlusion;
- Treatment of accidental or self-inflicted injuries, including setting of fractures and dislocation;
- General anesthesia or intravenous or inhalation sedation, unless medically necessary;
- Prescription or non-prescription drugs;
- Prosthetic appliances related to periodontics;
- Replacement of appliances (dentures, space maintainers, crowns, etc.) lost or stolen within five years of installation;
- Charges for missed appointments;
- Removal of wisdom teeth unless of dental necessity; or
- Services of prosthodontists, and procedures requiring fixed prosthodontic restoration for complete oral rehabilitation or reconstruction.

Dental HMO and Access+ Dentist

- Services not performed, prescribed or authorized by the member's Dental Center, unless authorized by the Plan or when required in an emergency, as stated in the contract;
- Prophylaxis more often than once every six months;
- Precious metals;
- Unauthorized second opinions;
- Osseous grafts or periodontal surgery of any type more often than once every 36 months per quadrant;
- Any services the Dental Plan Administrator determines not to be of dental necessity (if dental standards indicate that a condition can be treated by a less costly alternative than that proposed by the attending dentist, benefits will be paid based on the less costly service);
- Certain orthodontic services, including treatment for non-handicapping malocclusion, surgical orthodontics, myofunctional therapy, changes in treatment necessitated by an accident, treatment for TMJ, cosmetic orthodontic appliances, replacement of lost or stolen appliances and treatment exceeding 24 months; and
- See Service Agreement Supplement for specific limitations on prosthodontics, dentures, restorative services, mouth rehabilitation, and pedodontics.

Access+ Dentist only

- All orthodontic services
- Services performed by specialists

Glossary

This is a list of common concepts and terms that may apply to your Blue Shield health plan. Once you have become a Blue Shield member, please refer to your EOC/COI for the official definitions of these terms.

Affiliate Hospital

Plan hospitals that have agreed to accept Blue Shield's payment, plus subscriber payments of any applicable deductibles, copayments and/or coinsurance as payment-in-full for covered services. Services received through **Affiliate** hospitals may be subject to higher copayments/coinsurance. Payments made to **Affiliate** hospitals will accrue to the calendar-year non-preferred out-of-pocket maximum or copayment maximum.

Balance Billing

Amounts charged by non-preferred (non-network) providers above the Blue Shield allowable amount, for which members are responsible.

Blue Shield Allowable Amounts

The Blue Shield allowance for the service(s) rendered, or the provider's billed charge, whichever is less (as defined in the EOC/COI). These are the amounts that Blue Shield's preferred providers accept as payment-in-full for PPO plan covered services, which often are lower than their usual billed charges. After meeting any applicable plan deductible, PPO members pay a low percentage of the allowable amount when using preferred providers. They pay 50 percent of the allowable amount when using non-preferred providers, plus "balance billing."

Blue Shield Preferred Provider

Providers who have contracted with Blue Shield to be part of our preferred provider network. Preferred providers render covered services to PPO plan members at reduced charges. Except for applicable deductibles, copayments and amounts above the plan's

benefit maximums, they will accept Blue Shield's payment as payment in full.

Calendar Year

The period beginning at 12:01 a.m. on January 1 and ending at 12:01 a.m. on January 1 of the next year.

Choice Hospital

Hospitals that have agreed to accept Blue Shield's payment, plus subscriber payments of any applicable deductible, copayments and/or coinsurance, as payment-in-full for covered services. In addition, participation in the quality and patient experience programs offered by Blue Shield may result in a hospital being classified as a **Choice** hospital. Payments made to **Choice** hospitals will accrue to the calendar-year out-of-pocket maximum or copayment maximum.

Copayment/Coinsurance

The portion of the allowable amount (coinsurance) or fixed fee (copayment) that members pay for covered services when receiving benefits. Copayments/coinsurance are the member's share of the cost of covered services. With PPO plans, some copayments/coinsurance only apply after you satisfy a plan deductible. Most HMO copayments apply right away, without having to meet any deductible.

Copayment Maximum or Out-of-Pocket Maximum

A limit on the amount a member might need to pay for many covered services during a calendar year. An out-of-pocket maximum (Access+ HMO, Shield Spectrum PPO Savings Plans) includes the plan deductible, while a copayment maximum (Shield Spectrum PPO Plans) does not.

Blue Shield Protects the Confidentiality of Your Personal and Health Information

Personal and health information includes both medical information and individually identifiable information, such as your name, address, telephone number and Social Security number. We will not disclose this information, except as permitted by law.

A statement describing Blue Shield's policies and procedures for preserving the confidentiality of medical records is available and will be furnished to you upon request. These policies and procedures are contained in our Notice of Privacy Practices, which you can obtain by calling Member Services at (800) 431-2809, or via mylifepath.com.

If you are concerned that Blue Shield may have violated your confidentiality or privacy rights, or you disagree with a decision that we have made about access to your personal and health information, you may contact us at:

Blue Shield Privacy Official
P.O. Box 272540
Chico, CA 95927-2540
Toll-free telephone contact:
(888) 266-8080
Email contact: BlueShieldCA_Privacy@blueshieldca.com

Once either type of maximum is reached, Blue Shield will pay 100 percent of the allowable amount for all applicable covered services for the remainder of the calendar year, up to specified maximums.

Copayments for certain PPO plan covered services, such as office visit copayments, generally do not count toward these maximums. These continue to be the member's responsibility.

Emergency Care

A true emergency situation requires immediate medical attention at the nearest facility to prevent death or disability due to a sudden trauma or illness, such as a stroke or broken leg. Emergency care is covered at your plan's highest level of benefits.

Family

The subscriber and all enrolled dependents.

Health Savings Account (HSA)

An HSA is a tax-advantaged personal savings or investment account intended for payment of medical expenses, including plan deductibles and copayments, as well as some medical expenses not covered by your health plan. Contributions to a qualified HSA are deductible from gross income for tax purposes and can be used tax-free to pay for qualified medical expenses. HSA funds may also be saved on a tax-deferred basis for the future.

Mental Health Services Administrator (MHSA Providers)

Blue Shield has contracted with a specialized healthcare service plan to act as Blue Shield's Mental Health Services Administrator (MHSA). Mental health and substance abuse services are delivered to Blue Shield members through the MHSA's network of participating providers.

Non-Preferred Providers

Providers who have not contracted with Blue Shield to be part of our preferred provider (PPO) network. Non-preferred providers often charge members more than Blue Shield allowable amounts. Some PPO plan benefits, such as preventive care and office visits with fixed copayments, are not covered when accessed from these providers.

Pre-existing Condition

An illness, injury or condition for which medical advice, diagnosis, care or treatment was recommended or received from a licensed health practitioner during the six months prior to the plan effective date.

Preventive Care

Preventive Care Services are those primary preventive medical services provided by a physician for the early detection of disease when no symptoms are present.

Urgent Care

Those covered services (other than Emergency Services) which are medically necessary to prevent serious deterioration of a member's health, alleviate severe pain, or treat an unforeseen illness, injury or medical condition with respect to which treatment cannot reasonably be delayed until the member returns to the plan's service area.

Waivered Condition

A condition that is excluded from coverage for charges and expenses incurred during the six (6) months beginning as of the effective date of coverage. A waived condition applies only to a condition for which medical advice, diagnosis, care, or treatment, including prescription drugs, was recommended or received from a licensed health practitioner during the six months immediately preceding the effective date of coverage.

Blue Shield Sales Offices

Personal attention, expert assistance

Northern California

Fresno

5250 N. Palm Avenue
Suite 120
Fresno, CA 93704
(559) 440-4000

Sacramento

11249 Gold Country Blvd.
Suite 160
Gold River, CA 95670
(916) 851-3400

San Francisco

50 Beale Street,
20th Floor
San Francisco, CA 94105
(888) 222-2755

San Jose

1735 Technology Drive
Building 4, Suite 100
San Jose, CA 95110-1058
(408) 452-6900

Walnut Creek

1331 North California Blvd.
Suite 110
Walnut Creek, CA 94596
(925) 927-7400

Southern California

Los Angeles

6701 Center Drive West
Suite 800
Los Angeles, CA 90045
(310) 670-4040

Ontario

3401 Centrelake Drive
Suite 400
Ontario, CA 91761
(909) 974-5200

Orange

770 The City Drive South
Suite 3500
Orange, CA 92868
(714) 663-4200

San Diego

591 Camino De La Reina
Suite 100
San Diego, CA 92108
(619) 686-4200

Santa Barbara/Ventura

1933 Cliff Drive
Suite 11
Santa Barbara, CA 93109
(805) 966-1693

Woodland Hills

6300 Canoga Avenue
Woodland Hills, CA 91367
(818) 598-8000

personal

- Californians have relied upon Blue Shield of California for more than 60 years of not-for-profit service
- Blue Shield of California Life & Health Insurance Company has provided life insurance and other specialty insurance for over 50 years
- One of California's largest PPO Networks – more than 45,000 physicians and over 350 hospitals
- Self-referral to participating specialists with Access+ HMO
- Chiropractic benefits
- Eye Care Network vision care programs
- Preventive care benefits to help members stay healthy
- Pharmacy coverage, including oral contraceptives
- Personalized online health and wellness support through mylifepath.com
- Reduced costs for alternative health services
- Optional term life insurance
- Short-term health insurance available
- Affordable HMO or PPO dental coverage
- Outstanding customer service

choice. flexibility. access.