

choosing your health plan

Effective July 1, 2008

we can help

Choosing a health plan can be confusing, but this booklet can help you understand and choose the coverage that's right for you. Inside you'll find information about how health coverage works and why you need it. You'll also find detailed descriptions of all our individual and family health plans to help you compare and select the plan that best meets your unique needs.

This booklet is a summary of plan information, and is not a contract. The actual complete terms and conditions of a plan's benefits and coverage, limitations, and exclusions are located in the *Evidence of Coverage and Health Service Agreement (EOC)* or *Policy for Individuals and Families (Policy)*. We'll send you your EOC/Policy if your application is approved. If you have any questions or would like a copy of the EOC/Policy before you apply, simply call us at **(800) 431-2809**.

Please read this material completely and carefully. If you have specific healthcare needs, or would like to find out if the services you need are covered, be sure to read this booklet and the EOC/Policy before you apply for coverage. To review the Uniform Health Plan Benefits and Coverage Matrix (Uniform Matrix) for specific plans, please refer to the Table of Contents to see where they are located.

Please note: This booklet should be distributed only with a presale Important Legal Information document, which explains general plan exclusions and limitations. Both documents should be read together. If you do not receive the Important Legal Information document, you can obtain a copy by contacting your agent or calling Blue Shield of California at **(800) 431-2809**.

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find the right plan

Having quality healthcare coverage is important. Your health plan should fit your lifestyle, so that you're protected, but also ensure you aren't paying for benefits you don't think you'll need. With our wide range of affordable plans, Blue Shield of California can meet your specific needs and budget. All of our quality health plans provide easy access to:

- Some of the state's largest provider networks, so you can find the doctor you want
- Knowledgeable customer representatives who can quickly answer your questions
- Tools and resources to help you take control of your health and well-being



How a health plan works

You pay a set monthly rate for your health plan coverage and when you need medical services, your health plan pays for the majority of your medical costs once you've met your plan's medical deductible. Also, when you access participating providers you pay a fraction of the cost for the medical care you receive versus non-participating providers. In general, the higher the monthly rate, the lower the deductible.

Your costs for the healthcare services you receive – called your out-of-pocket costs – may include your **deductible, copayment, and/or coinsurance**. Depending on your plan, the maximum amount you have to pay each **calendar year** is called the **copayment/coinsurance maximum** or the **out-of-pocket maximum**.

Below are some important terms we believe you should know so you better understand the cost of health coverage. These general explanations can help you understand the terms you will find in a plan's benefit summary. For the contractual definitions of terms, see the EOC/Policy.

Allowable amount	The dollar amount considered payment in full for services rendered by Blue Shield and an associated network of healthcare providers.
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.
Coinsurance	The percentage share of the cost of covered healthcare services that the patient must pay. For example, if the allowable amount is \$100 and your coinsurance is 20%, you pay \$20 (20%) and your health plan pays \$80 (80%). (Note that some plans may not pay for some services until after you meet your deductible.)
Copayment (or copy)	The fixed fee for utilizing network services such as doctor or emergency room visits and filling a prescription. If your office visit copayment is \$20, you would pay that amount each time you see your doctor. (Note that some plans may not pay for some services until after you meet your deductible.)
Copayment/coinsurance maximum	A dollar limit on the amount a member may have to pay for many covered services in a calendar year. This limit <i>may include</i> the plan deductible, depending on the plan.
Covered services	Medical services that are covered by your health plan.
Deductible	The amount you must pay each year for most covered services before your plan begins to pay. For some covered services, such as preventive care, your plan may pay for treatment before you meet the deductible.
Family deductible	This applies if you have family coverage and a plan with a family deductible. The individual deductibles paid by covered family members count toward the family deductible, and once the family deductible is met, the individual deductibles are also met. Certain payments for services with preferred and non-preferred providers may count toward the deductible.
Formulary	Our preferred list of covered generic and brand-name drugs. You pay less for formulary than for non-formulary drugs.
Non-preferred provider (PPO plans only)	A provider that is not in the Blue Shield PPO network (also called a non-network provider).
Out-of-pocket maximum	A dollar limit on the total amount you have to pay for many covered services in a calendar year, <i>including</i> the deductible.
Personal Physician (HMO plans only)	The network physician who serves as an HMO member's designated primary healthcare provider and provides or coordinates all of the member's care.
Preferred provider (PPO plans only)	A provider who is part of the Blue Shield PPO network (also called a network provider). PPO members pay less when they see preferred providers.

Why health coverage is important

We hope you stay healthy, but accidents can happen. If you do need medical care, health coverage can help you manage your expenses and control your financial risk. Without coverage, medical costs* could be quite large and you could pay, in certain instances, the costs described below.



You have to spend a day in the hospital after an accident.
Average day in hospital: **\$11,989**



You badly injure your knee.
Knee replacement surgery and care (average day in hospital): **\$21,011**



You have a head injury.
Skull fracture, intracerebral hemorrhage: **\$8,913**



You need to be flown to the hospital.
Air ambulance, plus a day in the hospital: **\$25,756**

You can afford a health plan

With our health plans as low as \$45[†] a month, you can get dependable coverage for as little as \$1.50 a day. And saving may not be as hard as you think. For the price of a few discretionary items, you could have the Blue Shield monthly health coverage you need.

 +  +  = **\$50** (enough for health coverage!)

* These costs compare an average day billed charges to an average day allowed charges for a Blue Shield of California Individual and Family Plan (IFP) in 2007. Costs may vary depending on region and provider.

† Individual ages 19-29, Tier 1, living in Contra Costa, California, July 2008. Rates may vary, and are for people in good health.



FAQs

Here are answers to some commonly asked questions about how our health plans work.

Is my doctor part of a Blue Shield network?

Blue Shield offers one of the largest HMO and PPO networks in California. You can find out whether your doctor participates in our network by going to *Find a Provider* on our Web site, blueshieldca.com, or by calling **(800) 431-2809**. You'll also be able to locate network hospitals, dentists, optometrists, dermatologists, mental health providers, chiropractors, and acupuncturists.

- Some plans offer individual coverage only, which means that they don't have two-party or family coverage options.
- Some of our plans do not include maternity benefits or brand-name prescription drug benefits, and may also have certain limits on benefits (such as doctor visits in a calendar year).
- Some of our plans do not have a medical deductible.

Is my prescription on the Blue Shield formulary?

To see which drugs we cover, go to blueshieldca.com and click on *Pharmacy*, then click on *Drug Database and Formulary* to search for the drug name. Also check specific plan information in this booklet to see a plan's prescription coverage.

What is the difference between an HMO and a PPO?

There are many differences between a health maintenance organization (HMO) plan and a preferred provider organization (PPO) plan, but the most significant is how you access care. With an HMO, you and all family members covered by the plan must live or work in an area served by the plan, and access all your care in the plan provider network, through a Personal Physician that you choose. With our PPO plans, you may visit any licensed doctor, in or out of the network, without a referral from a Personal Physician.

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

Here are some basic differences:

- In general, the higher the calendar-year deductible for a PPO plan, the lower the monthly rates.
- Each of our PPO plans has a different calendar-year deductible and benefit levels.
- Plans with lower deductibles tend to have more generous prescription drug benefits and lower office visit copayments.

How do deductibles work?

If your health plan has a deductible, you must pay this amount each year before Blue Shield makes payments toward covered services. Depending on your plan, some services, such as preventive care, may be covered by Blue Shield before you meet your deductible.

In addition, if your plan has an individual and family deductible and you have family coverage, a *family deductible* applies. This means that the individual deductibles paid by covered family members count toward the family deductible, and once the family deductible is met, all individual deductibles are also met.

Is preventive care covered?

Yes. To help our members stay healthy, all Blue Shield health plans cover a range of preventive care such as routine physical exams, immunizations, well-baby care, and annual gynecological exams before any deductible must be met. To see if a particular preventive benefit is covered, please refer to your plan's EOC/Policy.

Can individual family members have different plans?

Yes. It may better suit your needs to place family members on different plans. You may also save money by putting your child on his or her own plan with special YouthCareSM rates instead of having a single family plan.

For specific benefit details, see the plan's EOC/Policy, or call us at **(800) 431-2809**.

Which Blue Shield plan is best for you?

Whatever your situation, we have coverage that is right for you. Let us help you identify your coverage needs and decide which plans may best meet them.

Who	Plan to consider	Why?
David and Victoria are married, go to the doctor for their regular checkups, and prefer to pay lower monthly dues. Because they have enough savings, they feel comfortable paying a higher deductible in an emergency.	Shield Spectrum PPO Savings Plan*	<ul style="list-style-type: none"> • With three deductible levels to choose from, the couple can pick the plan that best fits their coverage needs and cost. • Preventive care, office visits, and ER care are covered right away, before they meet the deductible. • Health Savings Account eligible
Brandon is a recent college graduate who works for a friend's moving company. He goes to the doctor infrequently, but wants coverage in case of a major medical event like hospitalization or surgery. He also wants low monthly rates, and office-visit coverage before meeting the deductible.	Vital Shield plan*	<ul style="list-style-type: none"> • Monthly rates start at \$45** • The plan covers two office visits each calendar year before Brandon needs to meet his deductible. • In case of a major medical event, Brandon is covered 100% after he meets the copayment maximum (\$4,900 or \$5,900).
Kelly works part-time in retail sales and does not have health coverage through her employer. She goes to the doctor infrequently and is not planning to get pregnant right now.	Essential plan*	<ul style="list-style-type: none"> • It's affordable individual coverage with low copayments for preventive-care office visits. • Manageable out-of-pocket medical costs so she's covered at 100% after the deductible is met.
Frank and Maria are a young couple who want comprehensive coverage for themselves and their daughter. They don't go to the doctor often, but their daughter does. They want a plan that will make their daughter's healthcare costs predictable.	PPO Plan 5000* for Frank and Maria; Access+ Value HMO YouthCare plan for their daughter	<p>With two different plans, they can best meet their family's coverage needs.</p> <p>PPO Plan 5000</p> <ul style="list-style-type: none"> • Covers Frank and Maria in an emergency, and covers their annual physical exams for a flat copayment before they meet their deductible. <p>Access+ Value HMO</p> <ul style="list-style-type: none"> • Lets them take their daughter to the doctor as often as necessary and keeps their out-of-pocket costs down. • Has fixed copayments for physician office visits, hospital services and prescription drugs, and no charge for preventive care services. • YouthCare rates reduce their monthly premiums.

* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life). Active Start plans and Vital Shield plans are individual-only plans and do not provide maternity benefits. Vital Shield plans 900 and 2900 and PPO Savings Plan 1800/3600 are subject to regulatory approval. a

** Individual ages 19-29, Tier – living in Contra Costa, CA, July 2008. Vital Shield rates may vary and are for people in good health.



Which Blue Shield plan is best for you?

(continued)

Plan features/ coverage	Vital Shield SM plans*	Active Start SM plans*	Essential SM plans*	Balance SM plans*	Shield Spectrum PPO SM Savings plans*	Shield Spectrum PPO SM plans*	HMO plans
Individual only	•	•	•				
For couples or families				•	•	•	•
No medical deductible		•					
Preventive care not subject to the deductible	•	N/A	•	•	•	•	•
HSA-compatible					•		
Chiropractic		•		•	•	PPOs 500-2000 plans only	
Acupuncture		•		•			
Maternity					PPO Savings Plan 2400/4800 only	•	•
Dental			•				Access+ HMO only
Vision			•				
Brand-name prescriptions		• (excludes Generic Rx plans)		•	•	•	•

* Vital Shield plans, Active Start plans, Essential plans, Balance plans, PPO Savings Plans 1800/3600 and 4000/8000, and PPOs 1500, 2000, and 5000 are underwritten by Blue Shield Life. Blue Shield of California and Blue Shield Life each offer a PPO 1500 and 2000.



understanding plan benefits



Vital Shield plans

NEW! Vital Shield 900

Vital Shield 2900

Underwritten by Blue Shield of California Life & Health Insurance Company. Pending regulatory approval. Vital Shield 900 plan benefits are effective May 1, 2008.

Protect yourself with our lowest-priced PPO plan for individuals.

Our Vital ShieldSM plans cover you with basic benefits and a low or moderate deductible choice in case of hospitalization, surgery, or other major medical events. This lower-priced PPO option covers two office visits and generic drugs, before you have to meet a deductible.

Vital Shield advantages

- Monthly rates starting at as low as \$45.*
- Choice of low or moderate annual deductible (\$900 or \$2,900).
- You're covered at 100% after you meet the copayment maximum.
- Low copayments for generic prescription drugs at network pharmacies (\$10).
- The calendar-year office visits, which can be used for preventive care, before you have to meet the deductible.
- One of California's largest PPO provider networks, so it's easy to find a doctor you want.
- Knowledgeable customer service representatives ready to help you and answer your questions.

Is a Vital Shield plan right for you?

Our lowest-priced PPO plans give you affordable coverage and protect you in case of major medical events, such as hospitalization. They are available for individuals only and offer basic benefits, so that you don't pay for services you don't expect to use, including maternity care or brand-name drug benefits.

* Individual ages 19-29, Tier 1, living in Contra Costa, California, July 2008. Rates may vary, and are for people in good health.

Vital Shield plans

Underwritten by Blue Shield of California Life & Health Insurance Company. Pending regulatory approval. Vital Shield 900 plan benefits are effective May 1, 2008.

Uniform Health Plan Benefits and Coverage Matrix

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

	Vital Shield 900	Vital Shield 2900
Deductible	\$900	\$2,900
Coinsurance	40% with preferred providers 50% with non-preferred providers	40% with preferred providers 50% with non-preferred providers
Calendar-year copayment/coinsurance maximum (includes the plan deductible – some services do not apply)	Services with preferred providers: \$4,900 Services with all providers: \$7,900	Services with preferred providers: \$5,900 Services with all providers: \$8,900
Lifetime maximum	\$3,000,000	\$3,000,000

- Plan benefits that are available before you need to meet the medical plan deductible are shown below with a dot. For all benefits without a dot, you are responsible for all charges up to the allowable amount or billed charges with preferred and non-preferred providers until the deductible is met. At that point, you will be responsible for the coinsurance noted in the chart below when accessing preferred and non-preferred providers.

The benefits below apply to both the Vital Shield 900 and Vital Shield 2900 plans.

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 (first 2 visits/calendar year for any combination of preventive care and physician office visits – subsequent visits are subject to the copayment maximum)	\$40 ^{2,*} •	No charge after copay maximum ²
Preventive care		
Annual routine physical exam, well-baby care office visits, and gynecological exam office visit (first 2 visits/calendar year for any combination of preventive care and physician office visits – subsequent visits are subject to the copayment maximum)	\$40 ^{2,*} •	Not covered
Annual 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% •	Not covered
Outpatient services		
Non-emergency services and procedures, outpatient surgery in hospital	40%	50% ^{2,3}
Outpatient surgery performed in an ambulatory surgery center (ASC) ⁴	40%	50% ²
Outpatient or out-of-hospital X-ray and laboratory	No charge after copay maximum ²	No charge after copay maximum ²
Hospitalization services		
Inpatient physician visits and consultations, surgeons and assistants, and anesthesiologists	40%	50%
Inpatient semiprivate room and board, services and supplies, and subacute care	40%	50% ^{2,3}
Bariatric surgery inpatient services (pre-authorization required: medically necessary surgery for weight loss, only for morbid obesity) ⁵	40%	50% ^{2,3}
Emergency health coverage		
Emergency room services (\$100 copayment/visit waived if member is admitted directly to the hospital as an inpatient)	\$100/visit + 40%	\$100/visit + 40%
ER physician visits	40%	40%
Ambulance services (surface or air)	40%	40%
Prescription drug coverage⁶ (outpatient)		
Generic formulary drugs	\$10/prescription ² •	\$20/prescription ² •
Formulary brand-name drugs	Not covered	Not covered
Non-formulary brand-name drugs	Not covered	Not covered
	With preferred providers,¹ you pay	With non-preferred providers,¹ you pay
Durable medical equipment	Not covered	Not covered



Vital Shield plans

Covered services

Member copayments

Subject to the plan deductible unless noted.	With MHSA participating providers, ^{1,7} you pay	With MHSA non-participating providers, ^{1,7} you pay
Mental health services		
Inpatient hospital facility services	40%	50% ^{2,3}
Inpatient physician services	40%	50%
Outpatient visits for severe mental health conditions	40%	50% ^{2,3}
Outpatient visits for non-severe mental health conditions ⁸	Not covered	Not covered
Chemical dependency services (substance abuse)		
Inpatient hospital facility services for medical acute detoxification	40%	50% ^{2,3}
Inpatient physician services for medical acute detoxification	40%	50%
Outpatient visits ⁸	Not covered	Not covered
	With preferred providers,¹ you pay	With non-preferred providers,¹ you pay
Home health services (up to 90 pre-authorized visits per calendar year)	No charge after copay maximum ²	Not covered
Other		
Pregnancy and maternity care		
Outpatient prenatal and postnatal care	Not covered	Not covered
Delivery and all necessary inpatient hospital services	Not covered	Not covered
Family planning		
Consultations, tubal ligation, vasectomy, elective abortion	No charge after copay maximum ²	Not covered
Rehabilitation services		
Provided in the office of a physician or physical therapist	Not covered	Not covered
Out-of-state services (full plan benefits covered nationwide with the BlueCard® Program)	40% with BlueCard participating providers	50% with all other providers

Please note: Benefits are subject to modification for subsequently enacted state or federal legislation. Vital Shield 900 and 2900 are subject to regulatory approval.

- * Member has two visits per calendar year before the calendar-year copayment/coinsurance maximum is met. After the two visits are used for any one purpose, the member pays 100% of the allowable amount for all of these services until the calendar-year copayment/coinsurance maximum is met, with no accrual to deductible or copayment/coinsurance maximum.
- 1 Member is responsible for 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 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 or coinsurance plus any charges that exceed Blue Shield's allowable amount. Charges above the allowable amount do not count toward the plan deductible or copayment/coinsurance maximum.
- 2 These copayments do not count toward the copayment/coinsurance maximum. They will continue to be charged once it is reached (except for office visits, X-ray and laboratory, home health services, and family planning). See Policy for details.
- 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 Participating ASCs may not be available in all areas. Regardless of their availability, you can obtain outpatient surgery services from a hospital, or an ASC affiliated with a hospital with payment according to your health plan's hospital services benefits. The maximum allowed charge for non-emergency surgery and services performed in a non-participating ASC is \$300 per day. Members are responsible for 50% of this \$300 per day, plus all charges in excess of \$300.
- 5 Bariatric surgery is covered when pre-authorized by Blue Shield. However, for members residing in Imperial, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Barbara, and Ventura counties ("designated counties"), bariatric surgery services are covered only when performed at designated contracting bariatric surgery facilities and by designated contracting surgeons; coverage is not available for bariatric services from any other preferred provider, and there is no coverage for bariatric services from non-preferred providers. In addition, if prior authorized by Blue Shield, a member in a designated county who is required to travel more than 50 miles to a designated bariatric surgery facility will be eligible for limited reimbursement for specified travel expenses for the member and one companion. Refer to the Policy for further benefit details.
- 6 Prescription coverage differs for home self injectables. Please review the Policy before you purchase the plan.
- 7 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.
- 8 For MHSA participating providers, initial visit treated as if the condition were a severe mental illness or serious emotional disturbance of a child. For MHSA non-participating providers, initial visit treated as a MHSA participating provider.

Essential plans

Essential Plan 1750

Essential Plan 3000

Essential Plan 4500

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

Our EssentialSM plans limit the total annual amount you spend on copayments and deductibles, and include dental and vision coverage at no added cost. You get the essential coverage you need.

Essential plan advantages

- Comprehensive coverage – includes medical, dental, and vision care.
- Affordable monthly rates.
- Manageable out-of-pocket medical costs.
 - Your copayment maximum equals the deductible.
 - You're covered at 100% after the deductible is met.
- Affordable copayments for preventive care office visits (\$40) and generic prescription drugs at network pharmacies (\$10).
- Choice of three annual deductibles (\$1,750, \$3,000, and \$4,500).
- One of the largest PPO provider networks in California, so it's easy to find the doctor you want.
- LASIK discount program.*
- Knowledgeable customer service representatives who can assist you and quickly answer your questions.

These PPO plans for individuals are among our lowest-cost options, and make getting the coverage you need simple by combining medical, dental, and vision all in one plan.

Is an Essential plan right for you?

You know you need coverage for predictable – and unpredictable – events. And we know you don't want to spend a lot on monthly rates, but you realize dental and vision are important to your overall health and well-being. That's why our Essential plans provide the affordable quality coverage you need while limiting your possible out-of-pocket costs. The plans are available for individuals only and don't include maternity care or brand-name drug benefits.

* This discount program is not a benefit of the plan, and is offered in addition to the benefits covered under the plan. Blue Shield reserves the right to terminate this program without notice.



Essential plans

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

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	Essential Plan 1750	Essential Plan 3000	Essential Plan 4500
Deductible	\$1,750	\$3,000	\$4,500
Copayments	\$40 with preferred providers Not applicable with non-preferred providers	\$40 with preferred providers Not applicable with non-preferred providers	\$40 with preferred providers Not applicable with non-preferred providers
Calendar-year copayment/coinsurance maximum (includes the plan deductible – some services do not apply)	Services with preferred providers: \$1,750 individual-only; Services with all providers: \$8,000	Services with preferred providers: \$3,000 individual-only; Services with all providers: \$8,000	Services with preferred providers: \$4,500 individual-only; Services with all providers: \$8,000
Lifetime maximum	\$6,000,000	\$6,000,000	\$6,000,000

- Plan benefits provided before you need to meet any medical deductible are shown below with a dot. For all benefits without a dot, you are responsible for all charges up to the allowable amount or billed charges with preferred and non-preferred providers until the deductible is met. At that point, you will be responsible for the copayment or coinsurance noted in the chart below when accessing preferred and non-preferred providers.

The benefits below apply to all Essential plans.

Covered services

Member copayments

Subject to the plan deductible, unless noted.	With preferred providers, ¹ you pay	With non-preferred providers, ¹ you pay
Professional services		
Office visits (first 3 visits/calendar year – subsequent visits are subject to the deductible)	\$40 (no charge after deductible) •	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)	\$40 ² •	Not covered
Outpatient services		
Non-emergency services and procedures	No charge after deductible	50% ^{2,3}
Outpatient surgery in hospital	No charge after deductible	50% ^{2,3}
Outpatient surgery performed in an ambulatory surgery center (ASC) ⁴	No charge after deductible	50% ²
Outpatient or out-of-hospital X-ray and laboratory	No charge after deductible	50%
Hospitalization services		
Inpatient physician visits and consultations, surgeons and assistants, and anesthesiologists	No charge after deductible	50%
Inpatient semiprivate room and board, services and supplies, and subacute care	No charge after deductible	50% ^{2,3}
Bariatric surgery inpatient services (pre-authorization required: medically necessary surgery for weight loss, only for morbid obesity) ⁵	No charge after deductible	50% ^{2,3}

Essential plans

Covered services

Member copayments

Subject to the plan deductible unless noted.	With preferred providers, ¹ you pay	With non-preferred providers, ¹ you pay
Emergency health coverage		
Emergency room services (\$100 copayment/visit waived if the member is admitted directly to the hospital as an inpatient)	\$100/visit ² ●	\$100/visit ² ●
ER physician visits	No charge after deductible	No charge after deductible
Ambulance services (surface or air)	No charge after deductible	No charge after deductible
Prescription drug coverage (outpatient)	At participating pharmacies (up to a 30-day supply)	Mail service prescriptions (up to a 60-day supply)
Generic formulary drugs	\$10/prescription ² ●	\$20/prescription ² ●
Formulary brand-name drugs	Not covered	Not covered
Non-formulary brand-name drugs	Not covered	Not covered
	With preferred providers,¹ you pay	With non-preferred providers,¹ you pay
Durable medical equipment⁴	No charge after deductible	50%
	With MHPA participating providers,^{1,7} you pay	With MHPA non-participating providers,^{1,7} you pay
Mental health services		
Inpatient hospital facility services	No charge after deductible	50% ^{2,3}
Inpatient physician services	No charge after deductible	50%
Outpatient visits for severe mental health conditions (first 3 visits/ calendar year – subsequent visits subject to the deductible)	\$40 (no charge after deductible) ●	50%
Outpatient visits for non-severe mental health conditions (up to 20 visits per calendar year combined with chemical dependency visits) ⁸	No charge after deductible	Not covered
Chemical dependency services (substance abuse)		
Inpatient hospital facility services for medical acute detoxification	No charge after deductible	50% ^{2,3}
Inpatient physician services for medical acute detoxification	No charge after deductible	50%
Outpatient visits (up to 20 visits per calendar year combined with non-severe mental health visits) ⁸	No charge after deductible	Not covered
	With preferred providers,¹ you pay	With non-preferred providers,¹ you pay
Home health services (up to 60 pre-authorized visits per calendar year)	No charge after deductible	Not covered
Other		
Pregnancy and maternity care		
Outpatient prenatal and postnatal care	Not covered	Not covered
Delivery and all necessary inpatient hospital services	Not covered	Not covered
Family planning		
Tubal ligation, vasectomy, elective abortion	Not covered	Not covered
Rehabilitation services (up to 15 visits per calendar year combined with speech therapy visits)		
Provided in the office of a physician or physical therapist	No charge after deductible	50%
Chiropractic services		
	Not covered	Not covered
Out-of-state services (full plan benefits covered nationwide with the BlueCard Program)	No charge after deductible with BlueCard participating providers	50% with all other providers
Vision services⁹		
Vision exam	\$5 ² ●	\$5 ² ● (and charges above the allowable amount)



Essential plans

Covered services

Member copayments

Subject to the plan deductible unless noted.	With preferred providers, ¹ you pay	With non-preferred providers, ¹ you pay
Dental services are NOT subject to the plan medical deductible, but there is a \$50 dental deductible for some minor restorative services		
Dental services¹⁰		
Preventive and diagnostic (including routine oral exams, X-rays, and cleaning)	No charge ¹¹	All charges above the allowable amount
Minor restorative ² (subject to \$50 dental deductible, including amalgam and resin-based fillings)	\$35-\$100 ¹¹ (depending on procedure)	Member reimbursed per procedure reimbursement schedule

Please note: Benefits are subject to modification for subsequently enacted state or federal legislation. Essential Plan 1750 is subject to regulatory approval.

- Plan benefits provided before you need to meet the medical deductible.

- Member is responsible for 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 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 or coinsurance plus any charges that exceed Blue Shield's allowable amount. Charges above the allowable amount do not count toward the copayment/coinsurance maximum.
- These copayments do not count toward the copayment/coinsurance maximum, and will continue to be charged once the copayment/coinsurance 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.
- Participating ASCs may not be available in all areas. Regardless of their availability, you can obtain outpatient surgery services from a hospital, or an ASC affiliated with a hospital with payment according to your health plan's hospital services benefits. The maximum allowed charge for non-emergency surgery and services performed in a non-participating ASC is \$300 per day. Members are responsible for 50% of this \$300 per day, plus all charges in excess of \$300.
- Bariatric surgery is covered when pre-authorized by Blue Shield. However, for members residing in Imperial, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Barbara, and Ventura counties ("designated counties"), bariatric surgery services are covered only when performed at designated contracting bariatric surgery facilities and by designated contracting surgeons; coverage is not available for bariatric services from any other preferred provider, and there is no coverage for bariatric services from non-preferred providers. In addition, if prior authorized by Blue Shield, a member in a designated county who is required to travel more than 50 miles to a designated bariatric surgery facility will be eligible for limited reimbursement for specified travel expenses for the member and one companion. Refer to the Policy for further benefit details.
- All covered orthoses have a benefit maximum of \$500 per member per calendar year, except those services covered under the Diabetes Care benefit. All covered prosthetics have a benefit maximum of \$2,000 per member per calendar year. See Policy for details.
- 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.
- For MHSA participating providers, initial visit treated as if the condition were a severe mental illness or serious emotional disturbance of a child. For MHSA non-participating providers, initial visit treated as an MHSA participating provider.
- Vision exams are provided through MESVision network.
- Dental services provided through Dental Benefit Providers (DBP). Benefits limited to \$500 per calendar year combined. Three-month waiting period following the effective date of coverage for minor restorative services. Calendar-year medical deductible does not apply to preventive dental services.
- Blue Shield's payment is limited to \$500 per calendar year for Preventive and Diagnostic and Minor Restorative. Members are responsible for all charges that exceed \$500 per calendar year.

Active Start plans

Active Start Plan 25

Active Start Plan 25 Generic Rx

Active Start Plan 35

Active Start Plan 35 Generic Rx

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

Our Active StartSM plans offer a steady meld of cost and comprehensive benefits for active individuals who want coverage in case of a serious medical event, but also want to take care of their day-to-day healthcare needs, with no annual medical deductible.

Active Start plan advantages

- Two plans with generic-only prescription drug coverage options to help save costs.
- \$10 copayments for generic prescription drugs at participating pharmacies with all plans.
- Affordable coverage for individuals.
- One of California's largest PPO provider networks, so it's easy to find the doctor you want.
- No medical deductible to meet, so your coverage starts immediately.
- Low copayments for preventive care office visits (\$25/\$35).
- Benefits for alternative care such as chiropractic and acupuncture.
- Knowledgeable customer service representatives who can assist you and quickly answer your questions.

Get value right away with our no-deductible Active Start PPO plans.

Is an Active Start plan right for you?

These plans feature no medical deductible, low generic drug copayments, and low copayments for office visits and preventive care. The economical Active Start plans offer individual coverage only and do not provide maternity benefits.



Active Start plans

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

Uniform Health Plan Benefits and Coverage Matrix

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

	Active Start Plan 25, Active Start Plan 25 Generic Rx	Active Start Plan 35, Active Start Plan 35 Generic Rx
Deductible*	\$0	\$0
Copayments	\$25 with preferred providers Not applicable with non-preferred providers	\$35 with preferred providers Not applicable with non-preferred providers
Coinsurance	40% with preferred providers 50% with non-preferred providers	40% with preferred providers 50% with non-preferred providers
Calendar-year copayment/ coinsurance maximum (some services do not apply)	Services with preferred providers: \$6,000 Services with all providers: \$8,000	Services with preferred providers: \$7,500 Services with all providers: \$10,000
Lifetime maximum	\$6,000,000	\$6,000,000

* Benefits for covered brand-name drugs are subject to a brand-name drug deductible per person. The Active Start Plan 25 has a \$500 brand-name drug deductible, and the Active Start Plan 35 has a \$750 brand-name drug deductible. Active Start Plan 25 Generic Rx and Active Start Plan 35 Generic Rx do not offer brand-name drug coverage and are not subject to a brand-name drug deductible. Blue Shield Life's payments for brand-name prescriptions are limited to \$2,000 per calendar year.

Covered services

Member copayments

	With preferred providers, ¹ you pay		With non-preferred providers, ¹ you pay
	Active Start Plan 25, Active Start Plan 25 Generic Rx	Active Start Plan 35, Active Start Plan 35 Generic Rx	
Professional services			
Office visits	\$25	\$35	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)	\$25	\$35	Not covered
Outpatient services			
Non-emergency services and procedures	40%		50% ^{2,3}
Outpatient surgery in hospital	\$500/admit + 40%		50% ^{2,3}
Outpatient surgery performed in an ambulatory surgery center (ASC) ⁴	40%		50% ²
Outpatient or out-of-hospital X-ray and laboratory	40%		50%
Hospitalization services			
Inpatient physician visits and consultations, surgeons and assistants, and anesthesiologists	40%		50%
Inpatient semiprivate room and board, services and supplies, and subacute care	\$500/admit + 40%		50% ^{2,3}
Bariatric surgery inpatient services (pre-authorization required: medically necessary surgery for weight loss, only for morbid obesity) ⁵	\$500/admit + 40%		50% ^{2,3}

Active Start plans

Covered services

Member copayments

	With preferred providers, ¹ you pay		With non-preferred providers, ¹ you pay
	Active Start Plan 25, Active Start Plan 25 Generic Rx	Active Start Plan 35, Active Start Plan 35 Generic Rx	
Emergency health coverage			
Emergency room services (\$100 copayment/visit waived if the member is admitted directly to the hospital as an inpatient)	\$100/visit + 40%		Covered at same level as preferred provider
ER physician visits	\$25	\$35	Covered at same level as preferred provider
Ambulance services (surface or air)	40%		40%
Active Start Plan 25 and Active Start Plan 35			
Prescription drug coverage⁶ (outpatient)	At participating pharmacies (up to a 30-day supply)		Mail service prescriptions (up to a 60-day supply)
Generic formulary drugs	\$10/prescription ²		\$20/prescription ²
Formulary brand-name drugs	\$35/prescription ²		\$70/prescription ²
Non-formulary brand-name drugs	\$50 or 50%/prescription (whichever is greater) ²		\$100 or 50%/prescription (whichever is greater) ²
Brand-name drug deductible (brand-name drugs are subject to a brand-name drug deductible per person, per calendar year)	Active Start plan 25		Active Start plan 35
	\$500		\$750
Active Start Plan 25 Generic Rx and Active Start Plan 35 Generic Rx are also available. These plans do not cover brand-name drugs. All other plan benefits are the same.			
	With preferred providers, ¹ you pay		With non-preferred providers, ¹ you pay
	Active Start Plan 25, Active Start Plan 25 Generic Rx	Active Start Plan 35, Active Start Plan 35 Generic Rx	
Durable medical equipment⁷	40%		50%
	With MHSA participating providers,^{1,8} you pay		With MHSA non-participating providers,^{1,8} you pay
Mental health services			
Inpatient hospital facility services	\$500/admit + 40%		50% ^{2,3}
Inpatient physician services	40%		50%
Outpatient visits for severe mental health conditions	\$25	\$35	50%
Outpatient visits for non-severe mental health conditions (up to 20 visits per calendar year combined with chemical dependency visits) ⁹	40% ²		Not covered
Chemical dependency services (substance abuse)			
Inpatient hospital facility services for medical acute detoxification	\$500/admit + 40%		50% ^{2,3}
Inpatient physician services for medical acute detoxification	40%		50%
Outpatient visits (up to 20 visits per calendar year combined with non-severe mental health visits) ⁹	40% ²		Not covered



Active Start plans

Covered services	Member copayments		
	With preferred providers, ¹ you pay		With non-preferred providers, ¹ you pay
	Active Start Plan 25, Active Start Plan 25 Generic Rx	Active Start Plan 35, Active Start Plan 35 Generic Rx	
Home health services (up to 90 pre-authorized visits per calendar year)	40%		Not covered
Other			
Pregnancy and maternity care			
Outpatient prenatal and postnatal care	Not covered		Not covered
Delivery and all necessary inpatient hospital services	Not covered		Not covered
Family planning			
Consultations, tubal ligation, vasectomy, elective abortion	40%		Not covered
Rehabilitation services (up to 12 visits per calendar year combined with chiropractic and speech therapy visits – Blue Shield's payment is limited to \$25/visit with non-preferred providers)			
Provided in the office of a physician or physical therapist	40%		50%
Chiropractic services (up to 12 visits per calendar year combined with rehabilitation services and speech therapy visits)	40%		Not covered
Acupuncture (up to 12 visits per calendar year combined with acupressure - Blue Shield's payment is limited to \$25/visit)	50%		50%
Out-of-state services (full plan benefits covered nationwide with the BlueCard Program)	40% with BlueCard participating providers		50% with all other providers

Please note: Benefits are subject to modification for subsequently enacted state or federal legislation. Active Start Plan 25 Generic Rx and Active Start Plan 35 Generic Rx are subject to regulatory approval.

- Member is responsible for 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 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 or coinsurance plus any charges that exceed Blue Shield's allowable amount. Charges above the allowable amount do not count toward the copayment/coinsurance maximum.
- These copayments do not count toward the copayment/coinsurance maximum, and will continue to be charged once the copayment/coinsurance 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. Member is responsible for all charges that exceed \$250 per day.
- Participating ASCs may not be available in all areas. Regardless of their availability, you can obtain outpatient surgery services from a hospital, or an ASC affiliated with a hospital with payment according to your health plan's hospital services benefits. The maximum allowed charge for non-emergency surgery and services performed in a non-participating ASC is \$300 per day. Members are responsible for 50% of this \$300 per day, plus all charges in excess of \$300.
- Bariatric surgery is covered when pre-authorized by Blue Shield. However, for members residing in Imperial, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Barbara, and Ventura counties ("designated counties"), bariatric surgery services are covered only when performed at designated contracting bariatric surgery facilities and by designated contracting surgeons; coverage is not available for bariatric services from any other preferred provider, and there is no coverage for bariatric services from non-preferred providers. In addition, if prior authorized by Blue Shield, a member in a designated county who is required to travel more than 50 miles to a designated bariatric surgery facility will be eligible for limited reimbursement for specified travel expenses for the member and one companion. Refer to the Policy for further benefit details.
- If a member requests a brand-name drug or the physician indicates "dispense as written" (DAW) for a prescription when an equivalent generic drug is available, and the brand-name drug deductible has been satisfied, the member pays the generic copayment plus the difference between the brand and generic drug cost. Prescription coverage differs for home self-injectables. Blue Shield Life's payments for brand-name prescriptions are limited to \$2,000 per calendar year. Please review the Policy before you purchase the plan.
- All covered durable medical, orthoses, and prostheses 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.
- 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.
- For MHSA participating providers, initial visit treated as if the condition were a severe mental illness or serious emotional disturbance of a child. For MHSA non-participating providers, initial visit treated as an MHSA participating provider.

Balance plans

Balance Plan 1000

Balance Plan 1700

Balance Plan 2500

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

BalanceSM plans provide coverage for preventive care, doctor's office visits, generic prescription coverage, and ER care right away, before you meet your deductible. Additionally, they offer easy access to chiropractic care and acupuncture, and a wide range of other quality benefits.

Balance plan advantages

- A variety of deductibles.
- The plan's copayment/coinsurance maximum includes your medical deductible, so you'll pay only up to the copayment/coinsurance maximum in a calendar year.
- Doctor's office visits and preventive care are provided for a fixed copay (\$30) before you need to meet the deductible.
- Generic drugs for \$10.
- One of the state's largest PPO networks, so it's easy to find doctors and hospitals.
- Includes benefits for chiropractic care and acupuncture.
- Knowledgeable customer service representatives who can assist you and quickly answer your questions.

These PPO plans offer a sensible balance of comprehensive benefits with relatively low deductibles.

Is a Balance plan right for you?

You have a family and want the balance of solid coverage with a relatively low deductible and rates. You're reasonably healthy and want the benefits of acupuncture and chiropractic visits. All Balance plans provide the same copayments, so you can choose which deductible amount best suits your needs.



Balance plans

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

Uniform Health Plan Benefits and Coverage Matrix

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	Balance Plan 1000	Balance Plan 1700	Balance Plan 2500
Deductible*	\$1,000 (\$2,000 family)	\$1,700 (\$3,400 family)	\$2,500 (\$5,000 family)
Copayments	\$30 with preferred providers Not applicable with non-preferred providers	\$30 with preferred providers Not applicable with non-preferred providers	\$30 with preferred providers Not applicable with non-preferred providers
Coinsurance	30% with preferred providers, 50% with non-preferred providers	30% with preferred providers, 50% with non-preferred providers	30% with preferred providers, 50% with non-preferred providers
Calendar-year copayment/coinsurance maximum (includes the plan deductible – some services do not apply)	Services with preferred providers: \$5,500 (\$11,000 family) Services with all providers: \$8,500 (\$17,000 family)	Services with preferred providers: \$6,500 (\$13,000 family) Services with all providers: \$9,500 (\$19,000 family)	Services with preferred providers: \$7,500 (\$15,000 family) Services with all providers: \$10,500 (\$21,000 family)
Lifetime maximum	\$6,000,000	\$6,000,000	\$6,000,000

* Benefits for covered brand-name drugs are subject to a separate brand-name drug deductible per person per calendar year. Balance plans have a \$500 brand-name drug deductible. Blue Shield Life's payments for brand-name prescriptions are limited to \$2,500 per calendar year.

- Plan benefits provided before you need to meet any medical deductible are shown below with a dot. For all benefits without a dot, you are responsible for all charges up to the allowable amount or billed charges with preferred and non-preferred providers until the deductible is met. At that point, you will be responsible for the copayment or coinsurance noted in the chart below when accessing preferred and non-preferred providers.

The benefits below apply to all Balance plans.

Covered services

Member copayments

Subject to the plan deductible, unless noted.	With preferred providers, ¹ you pay	With non-preferred providers, ¹ you pay
Professional services		
Office visits	\$30 ² •	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)	\$30 ² •	Not covered
Outpatient services		
Non-emergency services and procedures	30%	50% ^{2,3}
Outpatient surgery in hospital	\$250/visit + 30%	50% ^{2,3}
Outpatient surgery performed in an ambulatory surgery center (ASC) ⁴	30%	50% ²
Outpatient or out-of-hospital X-ray and laboratory	30%	50%

Balance plans

Covered services

Member copayments

Subject to the plan deductible unless noted.	With preferred providers, ¹ you pay	With non-preferred providers, ¹ you pay
Hospitalization services		
Inpatient physician visits and consultations, surgeons and assistants, and anesthesiologists	30%	50%
Inpatient semiprivate room and board, services and supplies, and subacute care	30%	50% ^{2,3}
Bariatric surgery inpatient services (pre-authorization required: medically necessary surgery for weight loss, only for morbid obesity) ⁵	30%	50% ^{2,3}
Emergency health coverage		
Emergency room services (\$100 copayment/visit waived if the member is admitted directly to the hospital as an inpatient)	\$100/visit + 30% ●	\$100/visit + 30% ●
ER physician visits	30%	30%
Ambulance services (surface or air)	30%	30%
Prescription drug coverage⁶ (outpatient)	At participating pharmacies (up to a 30-day supply)	Mail service prescriptions (up to a 60-day supply)
Generic formulary drugs	\$10/prescription ² ●	\$20/prescription ² ●
Formulary brand-name drugs	\$35/prescription ²	\$70/prescription ²
Non-formulary brand-name drugs	\$50 or 50%, whichever is greater/prescription ²	\$100 or 50%, whichever is greater/prescription ²
Brand-name drug deductible (brand-name drugs are subject to a brand-name drug deductible per person, per calendar year)	\$500	
	With preferred providers,¹ you pay	With non-preferred providers,¹ you pay
Durable medical equipment⁷	30%	50%
	With MHSA participating providers,^{1,8} you pay	With MHSA non-participating providers,^{1,8} you pay
Mental health services		
Inpatient hospital facility services	30%	50% ^{2,3}
Inpatient physician services	30%	50%
Outpatient visits for severe mental health conditions	\$30 ² ●	50%
Outpatient visits for non-severe mental health conditions (up to 20 visits per calendar year combined with chemical dependency visits) ⁹	30%	Not covered
Chemical dependency services (substance abuse)		
Inpatient hospital facility services for medical acute detoxification	30%	50% ^{2,3}
Inpatient physician services for medical acute detoxification	30%	50%
Outpatient visits (up to 20 visits per calendar year combined with non-severe mental health visits) ⁹	30%	Not covered
	With preferred providers,¹ you pay	With non-preferred providers,¹ you pay
Home health services (up to 90 pre-authorized visits per calendar year)	30%	Not covered



Balance plans

Covered services	Member copayments	
	With preferred providers, ¹ you pay	With non-preferred providers, ¹ you pay
Subject to the plan deductible unless noted.		
Other		
Pregnancy and maternity care		
Outpatient prenatal and postnatal care	Not covered	Not covered
Delivery and all necessary inpatient hospital services	Not covered	Not covered
Family planning		
Consultations, tubal ligation, vasectomy, elective abortion	30%	Not covered
Rehabilitation services (up to 20 visits per calendar year combined with speech therapy visits)		
Provided in the office of a physician or physical therapist	30%	50%
Chiropractic services (up to 15 visits per calendar year combined with acupuncture – Blue Shield's payment is limited to \$25)	50%	Not covered
Acupuncture (up to 15 visits per calendar year combined with acupressure and chiropractic – Blue Shield's payment is limited to \$25)	50%	50%
Out-of-state services (full plan benefits covered nationwide with the BlueCard Program)	30% with BlueCard participating providers	50% with all other providers

Please note: Benefits are subject to modification for subsequently enacted state or federal legislation. Balance Plans 1000, 1700, and 2500 are subject to regulatory approval.

- Plan benefits provided before you need to meet the medical deductible.
- 1 Member is responsible for 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 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 or coinsurance plus any charges that exceed Blue Shield's allowable amount. Charges above the allowable amount do not count toward the copayment/coinsurance maximum.
- 2 These copayments/coinsurance do not count toward the copayment/coinsurance maximum, and will continue to be charged once the copayment/coinsurance 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. Member is responsible for all charges that exceed \$250 per day.
- 4 Participating ASCs may not be available in all areas. Regardless of their availability, you can obtain outpatient surgery services from a hospital, or an ASC affiliated with a hospital with payment according to your health plan's hospital services benefits. The maximum allowed charge for non-emergency surgery and services performed in a non-participating ASC is \$300 per day. Members are responsible for 50% of this \$300 per day, plus all charges in excess of \$300.
- 5 Bariatric surgery is covered when pre-authorized by Blue Shield. However, for members residing in Imperial, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Barbara, and Ventura counties ("designated counties"), bariatric surgery services are covered only when performed at designated contracting bariatric surgery facilities and by designated contracting surgeons; coverage is not available for bariatric services from any other preferred provider, and there is no coverage for bariatric services from non-preferred providers. In addition, if prior authorized by Blue Shield, a member in a designated county who is required to travel more than 50 miles to a designated bariatric surgery facility will be eligible for limited reimbursement for specified travel expenses for the member and one companion. Refer to the Policy for further benefit details.
- 6 If a member requests a brand-name drug or the physician indicates "dispense as written" (DAW) for a prescription when an equivalent generic drug is available, and the brand-name drug deductible has been satisfied, the member pays the generic copayment plus the cost difference between the brand and generic drug. Prescription coverage differs for home self-injectables. Please review the Policy before you purchase the plan. Blue Shield Life's payments for brand-name prescriptions are limited to \$2,500 per calendar year.
- 7 All covered durable medical equipment, orthoses, and prostheses have a combined benefit maximum of \$5,000 per member per calendar year, except those services covered under the diabetes care benefit. See Policy for details.
- 8 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.
- 9 For MHSA participating providers, initial visit treated as if the condition were a severe mental illness or serious emotional disturbance of a child. For MHSA non-participating providers, initial visit treated as an MHSA participating provider.

Shield Spectrum PPO plans

PPO Plan 5000*

PPO Plan 2000/Blue Shield Life PPO plan 2000*

PPO Plan 1500/Blue Shield Life PPO plan 1500*

PPO Plan 750

PPO Plan 500

Choose from a wide variety and range of monthly rates, calendar-year deductibles, and benefits.

*Underwritten by Blue Shield of California Life and Health Insurance Company (Blue Shield Life). Both Blue Shield of California and Blue Shield Life offer PPO plans 1500 and 2000.

Shield Spectrum PPOSM Plan advantages

- Wide range of annual deductibles, and when two or more family members are on one plan, each covered individual has his or her own individual deductible, in case only one person needs expensive medical care. The family deductible can be met by any family member or combination of family members.
- Many services are covered before you meet the annual deductible.
- Copayment/coinsurance maximums help contain costs, because your family copayment maximums are only twice the individual amount, no matter how many people are covered.
- Added protection of \$10,000 in *Critical Condition Protection*SM (CCP) with the PPO Plan 5000.*
- One of California's largest PPO provider networks, so it's easy to find a doctor or hospital you want.
- Knowledgeable customer service representatives who can assist you and quickly answer your questions.

Is a Shield Spectrum PPO plan right for you?

These plans make it easy to visit the doctors and specialists you want while offering a wide variety of deductible options to meet your needs. When you receive care from Blue Shield PPO network providers, your out-of-pocket costs are always less.

* *Critical Condition Protection* (CCP) is part of the Shield Spectrum PPO Plan 5000 (underwritten by Blue Shield of California Life & Health Insurance Company). Members who have a first incident of severe heart attack, severe stroke, or certain life-threatening cancers become eligible for this benefit. There are restrictions that apply. Payment related to the CCP benefit is not restricted to medical care expenses. Therefore, a portion of your monthly premium payment allocated to the CCP maximum 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 adviser.



Shield Spectrum PPO Plan 5000

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

Uniform Health Plan Benefits and Coverage Matrix

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	PPO 5000
Deductible*	\$5,000 (\$10,000 family)
Copayments	\$35 with preferred providers Not applicable with non-preferred providers
Coinsurance	30% with preferred providers 50% with non-preferred providers
Calendar-year copayment/coinsurance maximum (includes the plan deductible – some services do not apply)	Services with preferred providers: \$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 per calendar year.

● Plan benefits provided before you need to meet any medical deductible are shown below with a dot. For all benefits without a dot, you are responsible for all charges up to the allowable amount or billed charges with preferred and non-preferred providers until the deductible is met. At that point, you will be responsible for the copayment or coinsurance noted in the chart below when accessing preferred and non-preferred providers.

Covered services

Member copayments

Subject to the plan deductible, unless noted.	With preferred providers, ¹ you pay	With non-preferred providers, ¹ you pay
Professional services		
Office visits	\$35	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 ●	Not covered
Outpatient services		
Non-emergency services and procedures, outpatient surgery in hospital	30%	50% ^{2,3}
Outpatient surgery performed in an ambulatory surgery center (ASC) ⁴	30%	50% ²
Outpatient or out-of-hospital X-ray and laboratory	30%	50%
Hospitalization services		
Inpatient physician visits and consultations, surgeons and assistants, and anesthesiologists	30%	50%
Inpatient semiprivate room and board, services and supplies, and subacute care	30%	50% ^{2,3}
Bariatric surgery inpatient services (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity) ⁵	30%	50% ^{2,3}
Emergency health coverage		
Emergency room services	30%	30%
ER physician visits	30%	30%
Ambulance services (surface or air)	30%	30%
Prescription drug coverage ⁶ outpatient	At participating pharmacies (up to a 30-day supply)	Mail service prescriptions (up to a 60-day supply)
Generic formulary drugs	\$10/prescription ² ●	\$20/prescription ² ●
Formulary brand-name drugs	\$35/prescription ²	\$70/prescription ²
Non-formulary brand-name drugs	\$50 or 50%/prescription (whichever is greater) ²	\$100 or 50%/prescription (whichever is greater) ²
Brand-name drugs are subject to a \$500 brand-name drug deductible per person, per calendar year	\$500	
	With preferred providers,¹ you pay	With non-preferred providers,¹ you pay
Durable medical equipment ⁷	30%	50%

Shield Spectrum PPO Plan 5000

Covered services

Member copayments

Subject to the plan deductible, unless noted.	With MHSA participating providers, ^{1,8} you pay	With MHSA non-participating providers, ^{1,8} you pay
Mental health services		
Inpatient hospital facility services	30%	50% ^{2,3}
Inpatient physician services	30%	50%
Outpatient visits for severe mental health conditions	\$35	50%
Outpatient visits for non-severe mental health conditions (up to 20 visits per calendar year combined with chemical dependency visits)?	30%	Not covered
Chemical dependency services (substance abuse)		
Inpatient hospital facility services for medical acute detoxification	30%	50% ^{2,3}
Inpatient physician services for medical acute detoxification	30%	50%
Outpatient visits (up to 20 visits per calendar year combined with non-severe mental health visits)?	30%	Not covered
	With preferred providers,¹ you pay	With non-preferred providers,¹ you pay
Home health services (up to 90 pre-authorized visits per calendar year)	30%	Not covered
Other		
Pregnancy and maternity care		
Outpatient prenatal and postnatal care	30%	50%
Delivery and all necessary inpatient hospital services	30%	50% ^{2,3}
Family planning		
Consultations, tubal ligation, vasectomy, elective abortion	30%	Not covered
Rehabilitation services (up to 12 visits per calendar year combined with speech therapy visits)		
Provided in the office of a physician or physical therapist	30%	50%
Out-of-state services (full plan benefits covered nationwide with the BlueCard Program)	30% with BlueCard participating providers	50% with all other providers

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

- Plan benefits provided before you need to meet the medical deductible.

- 1 Member is responsible for 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 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 or coinsurance, plus any charges that exceed Blue Shield's allowable amount. Charges above the allowable amount do not count toward the plan deductible or copayment/coinsurance maximum.
- 2 These copayments do not count toward the copayment/coinsurance 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 Participating ASCs may not be available in all areas. Regardless of their availability, you can obtain outpatient surgery services from a hospital, or an ASC affiliated with a hospital with payment according to your health plan's hospital services benefits. The maximum allowed charge for non-emergency surgery and services performed in a non-participating ASC is \$300 per day; members are responsible for 50% of this \$300 per day, plus all charges in excess of \$300.
- 5 Bariatric surgery is covered when pre-authorized by Blue Shield. However, for members residing in Imperial, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Barbara, and Ventura counties ("designated counties"), bariatric surgery services are covered only when performed at designated contracting bariatric surgery facilities and by designated contracting surgeons; coverage is not available for bariatric services from any other preferred provider, and there is no coverage for bariatric services from non-preferred providers. In addition, if prior authorized by Blue Shield, a member in a designated county who is required to travel more than 50 miles to a designated bariatric surgery facility will be eligible for limited reimbursement for specified travel expenses for the member and one companion. Refer to the Policy for further benefit details.
- 6 If a member requests a brand-name drug, or the physician indicates "dispense as written" (DAW) for a prescription when an equivalent generic drug is available, and the brand-name drug deductible has been satisfied, the member pays the generic copayment plus the cost difference between the brand and generic drug. Prescription coverage differs for home self-injectables. Please review the Policy before you purchase the plan.
- 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 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.
- 9 For MHSA participating providers, initial visit treated as if the condition were a severe mental illness or serious emotional disturbance of a child. For MHSA non-participating providers, initial visit treated as an MHSA participating provider.



Shield Spectrum PPO Plans 500, 750, 1500, and 2000

Blue Shield of California and Blue Shield of California Life & Health Insurance Company each offer PPO Plan 1500 and 2000.

For the following benefit details, when referring to PPO 1500 and PPO 2000, it will also include Blue Shield Life Shield Spectrum PPO Plans 1500 and 2000.

Uniform Health Plan Benefits and Coverage Matrix

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

	PPO 500	PPO 750	PPO 1500	PPO 2000
Deductible*	\$500 (\$1,000 family)	\$750 (\$1,500 family)	\$1,500 (\$3,000 family)	\$2,000 (\$4,000 family)
Copayments	\$30 with preferred providers Not applicable with non-preferred providers	\$35 with preferred providers; Not applicable with non-preferred providers	\$40 with preferred providers; Not applicable with non-preferred providers	\$45 with preferred providers; Not applicable with non-preferred providers
Percentage copayments	25% with preferred providers; 50% with non-preferred providers	30% with preferred providers; 50% with non-preferred providers	30% with preferred providers; 50% with non-preferred providers	30% with preferred providers; 50% with non-preferred providers
Calendar-year copayment/coinsurance maximum (does not include the plan deductible – some services do not apply)	Services with preferred providers: \$3,500 (\$7,000 family) Services with all providers: \$7,000 (\$14,000 family)	Services with preferred providers: \$4,000 (\$8,000 family) Services with all providers: \$8,000 (\$16,000 family)	Services with preferred providers: \$4,500 (\$9,000 family) Services with all providers: \$9,000 (\$18,000 family)	Services with preferred providers: \$5,000 (\$10,000 family) Services with all providers: \$10,000 (\$20,000 family)
Lifetime maximum	\$6,000,000	\$6,000,000	\$6,000,000	\$6,000,000

* Benefits for covered brand-name drugs are subject to a separate brand-name drug deductible per person. PPOs 500 and 750 have a \$250 brand-name drug deductible, and PPOs 1500 and 2000 have a \$500 brand-name drug deductible.

• Plan benefits provided before you need to meet medical deductible are shown below with a dot. For all benefits without a dot, you are responsible for all charges up to the allowable amount or billed charges with preferred and non-preferred providers until the deductible is met. At that point, you will be responsible for the copayment or coinsurance noted in the chart below when accessing preferred and non-preferred providers.

Covered services

Member copayments

Subject to the plan deductible, unless noted.	With preferred providers, ¹ you pay				With non-preferred providers, ¹ you pay
	PPO 500	PPO 750	PPO 1500	PPO 2000	
Professional services					
Office visits	\$30 ² •	\$35 ² •	\$40 ² •	\$45 ² •	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 ² •	\$35 ² •	\$40 ² •	\$45 ² •	Not covered
Outpatient services					
Non-emergency services and procedures	25%		30%		50% ²⁻³
Outpatient surgery in hospital	\$250/admit + 25%		\$250/admit + 30%		50% ²⁻³
Outpatient surgery in performed in an Ambulatory Surgery Center (ASC) ⁴	25%		30%		50% ²
Outpatient or out-of-hospital X-ray and laboratory	25%		30%		50%

Shield Spectrum PPO Plans

Covered services

Member copayments

Subject to the plan deductible, unless noted.	With preferred providers, ¹ you pay				With non-preferred providers, ¹ you pay
	PPO 500	PPO 750	PPO 1500	PPO 2000	
Hospitalization services					
Inpatient physician visits and consultations, surgeons and assistants, and anesthesiologists	25%		30%		50%
Inpatient semiprivate room and board, services and supplies, and subacute care	\$250/visit + 25%		\$250/visit + 30%		50% ^{2,3}
Bariatric surgery inpatient services (pre-authorization required; medically necessary surgery for weight loss, only for morbid obesity) ⁵	\$250/visit + 25%		\$250/visit + 30%		50% ^{2,3}
Emergency health coverage					
Emergency room services (\$100 copayment/visit waived if admitted as an inpatient)	\$100/visit + 25%		\$100/visit + 30%		Covered at same level as preferred providers
ER physician visits	25%		30%		Covered at same level as preferred providers
Ambulance services (surface or air)	25%		30%		Covered at same level as preferred providers
PPO Plans 500 – 2000					
Prescription drug coverage⁶ (outpatient)	At participating pharmacies (up to a 30-day supply)			Mail service prescriptions (up to a 60-day supply)	
Generic formulary drugs	\$10/prescription ² ●			\$20/prescription ² ●	
Formulary brand-name drugs	\$35/prescription ²			\$70/prescription ²	
Non-formulary brand-name drugs	\$50 or 50%/prescription, whichever is greater (maximum copayment of \$150 per prescription) ²			\$100 or 50%/prescription, whichever is greater (maximum copayment of \$300 per prescription) ²	
Brand-name drug deductible (brand-name drugs are subject to a brand-name drug deductible per person, per calendar year)	PPO plans 500 and 750 \$250			PPO plans 1500 and 2000 \$500	
	With preferred providers,¹ you pay				With non-preferred providers,¹ you pay
	PPO 500	PPO 750	PPO 1500	PPO 2000	
Durable medical equipment⁷	25%		30%		50% (not covered for PPO 500 and 1500)
	With MHPA participating providers,^{1,8} you pay				With MHPA non-participating providers,^{1,8} you pay
Mental health services					
Inpatient hospital facility services	\$250/admit + 25%		\$250/admit + 30%		50% ^{2,3}
Inpatient physician services	25%		30%		50%
Outpatient visits for severe mental health conditions	\$30 ² ●	\$35 ² ●	\$40 ² ●	\$45 ² ●	50%
Outpatient visits for non-severe mental health conditions (up to 20 visits per calendar year combined with chemical dependency visits) ⁹	25%		30%		Not covered
Chemical dependency services (substance abuse)					
Inpatient hospital facility services for medical acute detoxification	\$250/admit + 25%		\$250/admit + 30%		50% ^{2,3}
Inpatient physician services for medical acute detoxification	25%		30%		50%
Outpatient visits (up to 20 visits per calendar year combined with non-severe mental health visits) ⁹	25%		30%		Not covered



Shield Spectrum PPO Plans

Covered services

Member copayments

Subject to the plan deductible, unless noted.	With preferred providers, ¹ you pay				With non-preferred providers, ¹ you pay
	PPO 500	PPO 750	PPO 1500	PPO 2000	
Home health Services (up to 90 pre-authorized visits per calendar year)	25%		30%		Not covered
Other					
Pregnancy and maternity care					
Outpatient prenatal and postnatal care	25%		30%		50%
Delivery and all necessary inpatient hospital services	\$250/admit + 25%		\$250/admit + 30%		50% ^{2,3}
Family planning					
Consultations, tubal ligation, vasectomy, elective abortion	25%		30%		Not covered
Rehabilitation services					
Provided in the office of a physician or physical therapist	25%		30%		50%
Chiropractic services (up to 12 visits per calendar year – Blue Shield's payment is limited to \$25)	50% ●		50% ●		Not covered
Out-of-state services (full plan benefits covered nationwide with the BlueCard Program)	25% with BlueCard participating providers		30% with BlueCard participating providers		50% with all other providers

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

● Plan benefits provided before you need to meet the medical deductible.

- Member is responsible for fixed dollar or percentage copayment or coinsurance in addition to any charges above allowable amounts. The coinsurance/copayment percentage indicated is a percentage of the allowable 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 or coinsurance plus any charges that exceed Blue Shield's allowable amount. Charges above the allowable amount do not count toward the plan deductible or copayment/coinsurance maximum.
- These copayments do not count toward the copayment/coinsurance 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.
- Participating ASCs may not be available in all areas. Regardless of their availability, you can obtain outpatient surgery services from a hospital, or an ASC affiliated with a hospital with payment according to your health plan's hospital services benefits. The maximum allowed charge for non-emergency surgery and services performed in a non-participating ASC is \$300 per day; members are responsible for 50% of this \$300 per day, plus all charges in excess of \$300.
- Bariatric surgery is covered when pre-authorized by Blue Shield. However, for members residing in Imperial, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Barbara, and Ventura counties ("designated counties"), bariatric surgery services are covered only when performed at designated contracting bariatric surgery facilities and by designated contracting surgeons; coverage is not available for bariatric services from any other preferred provider, and there is no coverage for bariatric services from non-preferred providers. In addition, if prior authorized by Blue Shield, a member in a designated county who is required to travel more than 50 miles to a designated bariatric surgery facility will be eligible for limited reimbursement for specified travel expenses for the member and one companion. Refer to the EOC/Policy for further benefit detail.
- If a member requests a brand-name drug, or the physician indicates "dispense as written" (DAW) for a prescription when an equivalent generic drug is available, and the brand-name drug deductible has been satisfied, the member pays the generic copayment plus the cost difference between the brand and generic drug. The \$150/\$300 max/prescription for non-formulary brand-name drugs does not apply to Blue Shield Life Shield Spectrum PPO Plans 2000 or 1500. Prescription coverage differs for home self-injectables. Please review the EOC/Policy before you purchase the plan.
- All covered orthotic equipment and services have a benefit maximum of \$1,000 per member per calendar year, except those services covered under the diabetes care benefit. All covered prostheses and durable medical equipment have a benefit maximum of \$2,000 per member per calendar year.
- 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.
- For MHSA participating providers, initial visit treated as if the condition were a severe mental illness or serious emotional disturbance of a child. For MHSA non-participating providers, initial visit treated as an MHSA participating provider.

Shield Spectrum PPO Savings Plans

NEW! PPO Savings Plan 1800/3600*

PPO Savings Plan 2400/4800

PPO Savings Plan 4000/8000*

*Underwritten by Blue Shield of California Life and Health Insurance Company. PPO Savings Plan 1800/3600 plan benefits are effective May 1, 2008.

These six high-deductible health plans are compatible with a Health Savings Account (HSA), which offer you easy access to quality care and protection against major healthcare expenses.

Shield Spectrum PPO Savings PlanSM advantages

- Choose from a wide range of deductibles.
- Your out-of-pocket maximum includes your plan deductible, so you'll pay only up to your plan's out-of-pocket maximum in a calendar year.
- Preventive care is provided for a fixed copayment before meeting any deductible.
- Get prescription drugs at our contracted rate at participating pharmacies.
- Convenient access to a mail service pharmacy benefit.
- No copay for covered prescription drugs once you meet the out-of-pocket maximum.
- The family deductible can be met by any family member or combination of family members. Once the family deductible is met, all remaining covered family members will have met their deductible.
- One of the state's largest PPO networks, so it's easy to find doctors and hospitals.
- Knowledgeable customer service representatives who can assist you and quickly answer your questions.

Choose from a wide range of monthly rates, calendar-year deductibles, and benefits. In addition, these six PPO plans are HSA-compatible.

A Health Savings Account adds value to your plan

These plans can be paired with an HSA, which can offer qualified members* the opportunity to save on taxes.

What is an HSA?

HSAs are personal savings or investment accounts that you combine with a high-deductible health plan. You contribute pre-tax dollars, which you can use to pay for qualified medical expenses. Depending on which HSA you choose, you can decide how much to contribute, what investments to make, how much to use for medical expenses, and which medical expenses to pay from the account.

If you enroll any of our the PPO Savings Plans** and are qualified to open an HSA, you can use your tax-free HSA funds to pay for qualified medical expenses, even those not covered by your health plan. These include dentist visits, eye exams, acupuncture, and more. You can also accumulate tax-free funds for future healthcare funding needs such as long-term care.

If I don't want an HSA, can I still choose a Shield Spectrum PPO Savings Plan?

Absolutely! These plans are PPO health plans and HSA participation is optional. Regardless of your eligibility for an HSA, you can choose a Shield Spectrum PPO Savings Plan for affordable rates, extensive coverage, and nationwide access to providers.

* Please note that consumers who enroll in an HSA-eligible high-deductible health plan may be eligible to open an HSA, but should consult with a financial and/or tax adviser to confirm and determine if an HSA is a good financial fit for them. Blue Shield does not offer tax advice or HSAs. HSAs are offered through financial institutions.

** PPO Savings Plans 1800/3600, 2400/4800 and 4000/8000 are intended to qualify as a "high-deductible health plan" for the purposes of qualifying for a Health Savings Account (HSA), within the meaning of Section 223 of the Internal Revenue Code of 1986, as amended.

NOTICE: Blue Shield does not provide tax advice. If you intend to 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. Although we believe that these plans meet these legal requirements, the Internal Revenue Service has not ruled on whether the plans are qualified as high-deductible health plans. If you purchase one of these plans to obtain the income tax benefits associated with an HSA and the Internal Revenue Service rules that these plans do not qualify as high-deductible health plans, 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 an HSA-eligible high-deductible health plan change, we intend to amend the Shield Spectrum PPO Savings Plans, if necessary, to meet the requirements of a qualified plan. The plan's monthly rates may also change as a result of a change in the plan(s).



Shield Spectrum PPO Savings Plans

HSA-compatible

PPO Savings Plan 1800/3600 plan benefits are effective May 1, 2008.

Uniform Health Plan Benefits and Coverage Matrix

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

	1800/3600 [†]	2400/4800	4000/8000 [†]
Deductible*	\$1,800 (\$3,600 family)	\$2,400 (\$4,800 family)	\$4,000 (\$8,000 family)
Percentage copayment/coinsurance	30% at preferred providers; 50% at non-preferred providers	30% at preferred providers 50% at non-preferred providers	No charge after deductible at preferred providers 50% with non-preferred providers
Calendar-year out-of-pocket maximum (includes the plan deductible)	Service with preferred providers: \$5,600 individual/\$11,200 family Services with all providers: \$10,000 Individual/\$20,000 family	Service with preferred providers: \$4,000 individual/\$7,200 family Services with all providers: \$6,000 Individual/\$10,000 family	Services with preferred providers: \$4,000 (\$8,000 family) Services with all providers: \$5,000 (\$10,000 family)
Lifetime maximum	\$6,000,000	\$6,000,000	\$6,000,000

Please note: The deductibles and out-of-pocket maximum amounts may increase annually to reflect federal cost-of-living adjustment.

* For two-party/family coverage: Only after the family deductible is met will any individual be eligible for benefits. The family deductible adds together applicable expenses accrued by all covered family members.

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

- Plan benefits provided before you need to meet any medical deductible are shown below with a dot. For all benefits without a dot, you are responsible for all charges up to the allowable amount or billed charges with preferred and non-preferred providers until the deductible is met. At that point, you will be responsible for the copayment or coinsurance noted in the chart below when accessing preferred and non-preferred providers.

Covered services

Member copayments

Subject to the plan deductible, unless noted.

	With preferred providers, ¹ you pay		With non-preferred providers, ¹ you pay
	1800/3600 and 2400/4800	4000/8000	
Professional services			
Office visits	\$35	No charge after deductible	50%
Preventive care			
Annual routine physical exam, gynecological exam, well-baby care office visits (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 ●	\$35 (no charge after deductible) ●	Not covered
Outpatient services			
Non-emergency services and procedures, outpatient surgery in a hospital	30%	No charge after deductible	50% ²
Outpatient surgery performed in an ambulatory surgery center (ASC) ³	30%	No charge after deductible	50%
Outpatient X-ray and laboratory	30%	No charge after deductible	50%
Hospitalization services			
Inpatient physician visits and consultations, surgeons and assistants, and anesthesiologists	30%	No charge after deductible	50%
Inpatient semiprivate room and board, services and supplies, and subacute care	30%	No charge after deductible	50% ²
Bariatric surgery inpatient services (pre-authorization required: medically necessary surgery for weight loss, only for morbid obesity) ⁴	30%	No charge after deductible	50% ²

Shield Spectrum PPO Savings Plans

Covered services

Member copayments

Subject to the plan deductible, unless noted.	With preferred providers, ¹ you pay		With non-preferred providers, ¹ you pay	
	1800/3600 and 2400/4800	4000/8000		
Emergency health coverage				
Emergency room services (\$75 copayment/visit waived if the member is admitted directly to the hospital as an inpatient)	\$75/visit + 30%	No charge after deductible	Covered at same level as preferred provider	
ER physician visits	30%	No charge after deductible	Covered at same level as preferred provider	
Ambulance services (surface or air)	30%	No charge after deductible	Covered at same level as preferred provider	
	At participating pharmacies (up to a 30-day supply)		Mail service prescriptions (up to a 60-day supply)	
Prescription drug coverage⁵ (outpatient, subject to the plan medical deductible)	1800/3600 and 2400/4800	4000/8000	1800/3600 and 2400/4800	4000/8000
Generic formulary drugs	\$10/prescription	No charge	\$20/prescription	Covered at same level as participating pharmacies
Formulary brand-name drugs	\$35/prescription	No charge	\$70/prescription	
Non-formulary brand-name drugs	\$50 or 50%/prescription, whichever is greater (maximum of \$150/prescription)	No charge	\$100 or 50%/prescription, whichever is greater (maximum of \$300/prescription)	
	With preferred providers,¹ you pay		With non-preferred providers,¹ you pay	
	1800/3600 and 2400/4800	4000/8000		
Durable medical equipment⁶	30%	No charge after deductible	50%	
	With MHSA participating providers,^{1,7} you pay		With MHSA non-participating providers,^{1,7} you pay	
	1800/3600 and 2400/4800	4000/8000		
Mental health services				
Inpatient hospital facility services	30%	No charge after deductible	50% ²	
Inpatient physician services	30%	No charge after deductible	50%	
Outpatient visits for severe mental health conditions	\$35	No charge after deductible	50%	
Outpatient visits for non-severe mental health conditions (up to 20 visits per calendar year combined with chemical dependency visits) ⁹	30%	No charge after deductible	Not covered	
Chemical dependency services (substance abuse)				
Inpatient hospital facility services for medical acute detoxification	30%	No charge after deductible	50% ²	
Inpatient physician services for medical acute detoxification	30%	No charge after deductible	50%	
Outpatient visits (up to 20 visits per calendar year combined with non-severe mental health visits) ⁹	30%	No charge after deductible	Not covered	
	With preferred providers,¹ you pay		With non-preferred providers,¹ you pay	
Home health services (up to 90 pre-authorized visits per calendar year) ⁹	30%	No charge after deductible	Not covered	



Shield Spectrum PPO Savings Plans

Covered services

Member copayments

Subject to the plan deductible, unless noted.	With preferred providers, ¹ you pay		With non-preferred providers, ¹ you pay
	1800/3600 and 2400/4800		4000/8000

Other

Pregnancy and maternity care

Outpatient prenatal and postnatal care	30% (not covered for 1800/3600)	Not covered	50% (not covered for PPO Savings Plans 1800/3600 and 4000/8000)
Delivery and all necessary inpatient hospital services	30% (not covered for 1800/3600)	Not covered	50% ² (not covered for PPO Savings Plans 1800/3600 and 4000/8000)

Family planning

Consultations, tubal ligation, vasectomy, elective abortion	30%	No charge after deductible	Not covered
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Rehabilitation services⁸

Provided in the office of a physician or physical therapist	30% ⁹ (up to 20 visits per calendar year)	No charge after deductible	50%
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Chiropractic services

(up to 12 visits per calendar year – Blue Shield's payment is limited to \$25/visit)	50%	No charge after deductible	Not covered
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Out-of-state services

(full plan benefits covered nationwide with the BlueCard Program)	30% with BlueCard participating providers	No charge after deductible with BlueCard participating providers	50% with all other providers
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Please note: Benefits are subject to modification for subsequently enacted state or federal legislation. Shield Spectrum PPO Savings Plan 1800/3600 is subject to regulatory approval.

- Plan benefits provided before you need to meet the medical 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'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.
- 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 Participating ASCs may not be available in all areas. Regardless of their availability, you can obtain outpatient surgery services from a hospital, or an ASC affiliated with a hospital with payment according to your health plan's hospital services benefits. The maximum allowed charge for non-emergency surgery and services performed in a non-participating ASC is \$300 per day. Members are responsible for 50% of this \$300 per day, plus all charges in excess of \$300.
- 4 Bariatric surgery is covered when pre-authorized by Blue Shield. However, for members residing in Imperial, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Barbara, and Ventura counties ("designated counties"), bariatric surgery services are covered only when performed at designated contracting bariatric surgery facilities and by designated contracting surgeons; coverage is not available for bariatric services from any other preferred provider, and there is no coverage for bariatric services from non-preferred providers. In addition, if prior authorized by Blue Shield, a member in a designated county who is required to travel more than 50 miles to a designated bariatric surgery facility will be eligible for limited reimbursement for specified travel expenses for the member and one companion. Refer to the EOC/Policy for further benefit details.
- 5 If a member requests a brand-name drug or the physician indicates dispense as written (DAW) for a prescription, when an equivalent generic drug is available, and the brand-name drug deductible has been satisfied, the member pays the generic copayment plus the cost difference between the brand and generic drug, and it will not accrue to the copayment maximum. Prescription coverage differs for home self-injectables. Some prescriptions will require prior authorization to obtain coverage (see formulary). Use of ID card is required to obtain prescriptions from pharmacy or claim(s) will be denied. Please review the EOC/Policy before you purchase the plan.
- 6 For PPO Savings Plans 1800/3600 and 2400/4800, all covered orthotic equipment and services have a benefit maximum of \$2,000 per member per calendar year, except those services covered under the prosthetic appliances, durable medical equipment, or the diabetes care benefit. For PPO Savings Plan 4000/8000, all covered durable medical equipment, prosthetic, and orthotic 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.
- 7 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.
- 8 Limit applies to visits to participating and non-participating providers combined for PPO Savings Plans 1800/3600 and 2400/4800. Additional visits will be authorized if Blue Shield determines that additional treatment is medically necessary.
- 9 For MHSA participating providers, initial visit treated as if the condition were a severe mental illness or serious emotional disturbance of a child. For MHSA non-participating providers, initial visit treated as an MHSA participating provider.

HMO Plans

Access+ Value HMO

Access+ HMO

Before having to meet a deductible, you'll have easy access to a wide range of routine and preventive care services for a small copayment.

Access+ Value HMOSM and Access+ HMO[®] plan advantages

- Affordable \$20/\$35 office visit copayments; \$10 copayments for generic drug prescriptions.
- See a specialist in your Personal Physician's participating medical group/IPA without a referral for a \$35/\$50 copayment.
- One of the largest HMO networks in California, so it's easy to find a doctor or hospital.
- Basic dental services included with Access+ HMO.
- No lifetime maximum on plan benefits.
- Practically no claim forms.
- Knowledgeable customer service representatives who can assist you and quickly answer your questions.

Personal care from your Personal Physician

The relationship you have with your Personal Physician is the key to your HMO plan.

He or she:

- Provides or coordinates all your necessary medical services; and
- Arranges for referrals to specialists, hospitals, and other covered non-physician healthcare practitioners.

Our affordable HMO plans offer a predictable, cost-efficient way to manage your health care, especially if you or your dependents visit the doctor often. These plans may also help you to navigate the healthcare system.

Money-back guarantee:

Our member feedback program, Access+ Satisfaction,SM will refund your office-visit copayment if you are ever dissatisfied with the service you receive during a covered office visit with an HMO network physician. It will also provide a postage-paid postcard for your comments so you can share your valuable feedback with us.

Special features

Direct access to specialists

With Access+ *Specialist*SM you can go directly to a specialist or another physician in the same medical group or IPA as your Personal Physician, without a referral. When you do, depending on your plan, your copayment will be \$35/\$50 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.

Direct access to gynecological exams and OB/GYN visits

Women can 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 exams, without a referral.



HMO Plans

Uniform Health Plan Benefits and Coverage Matrix

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

	Access+ Value HMO	Access+ HMO Plan
Deductible*	\$2,000 (\$4,000 family)	\$2,000 (\$4,000 family)
Calendar-year copayment maximum (includes the plan deductible – some services do not apply)	\$4,000 (\$8,000 family)	\$3,000 (\$6,000 family)
Lifetime maximum	No limit	No limit

* Benefits for covered brand-name drugs are subject to a separate brand-name drug deductible per person for formulary and non-formulary. Access+ Value HMO has a \$400 brand-name drug deductible, and Access+ HMO has a \$200 brand-name drug deductible.

All the benefits listed below are covered by the Access+ Value HMO and Access+ HMO plans. Plan services and supplies are covered when performed, prescribed, or authorized by your Personal Physician. Other than the exceptions listed on page 32, services that are not obtained from or approved by your Personal Physician will not be covered.

● Plan benefits provided before you need to meet any medical deductible are shown below with a dot.

Covered services¹

Member copayments

	Access+ Value HMO	Access+ HMO
Professional services		
Personal Physician office visits	\$35/visit ●	\$20/visit ●
Injectable medications, lab, and X-ray	\$35 ●	\$20 ●
Access+ Specialist (self-referred physician office visits or other consultations only) ³	\$50/visit ² ●	\$35/visit ² ●
Physician home visits	\$50 ●	\$35 ●
Preventive care		
Scheduled routine physical exams, annual gynecological exam, immunizations, vision, hearing, and routine lab screenings	\$35 ●	\$20 ●
Outpatient services		
Outpatient surgery (in a hospital)	40%/visit	\$250/visit
Outpatient surgery performed in an ambulatory surgery center (ASC) ⁴	\$150/visit	\$150/visit
Outpatient services and supplies (in a hospital; includes radiation and intravenous chemotherapy)	40%/visit ●	\$35/visit ●
Outpatient or out-of-hospital X-ray and laboratory	\$35/visit ●	\$20/visit ●
Hospitalization services		
Inpatient physician visits and consultations, surgeons and assistants, and anesthesiologists (covered inpatient hospital, skilled nursing facility, and subacute care physician services)	\$35/visit ●	\$20/visit ●
Inpatient semiprivate room and board, intensive care units, subacute care, special treatment rooms, services, and supplies	40%/admit	\$250/admit
Emergency health coverage		
Emergency room facility services (copayment/visit waived if the member is admitted directly to the hospital as an inpatient)	\$150/visit ●	\$75/visit ●
Ambulance services (surface or air)		
	\$50/trip ●	\$50/trip ●

HMO Plans

Covered services

Member copayments

	Access+ Value HMO and Access+ HMO	
Prescription drug coverage^{5,6}	At participating pharmacies (up to a 30-day supply)	Mail service prescriptions (up to a 60-day supply)
Generic drugs	\$10/prescription ² ●	\$20/prescription ² ●
Formulary brand-name drugs	\$35/prescription ²	\$70/prescription ²
Brand name drug deductible (brand-name drugs subject to a brand-name drug deductible per person, per calendar year)	Access+ Value HMO \$400	Access+ HMO \$200
	Access+ Value HMO	Access+ HMO
Durable medical equipment⁷	50% ² ●	50% ² ●
Mental health services⁸		
Inpatient hospital facility services	40%/admit	\$250/admit
Inpatient physician services	\$35/visit ●	\$20/visit ●
Outpatient visits for severe mental health conditions	\$35/visit (\$50/visit ² if provider is MHSA Access+ Specialist provider) ³ ●	\$20/visit (\$35/visit ² if provider is MHSA Access+ Specialist provider) ³ ●
Outpatient visits for non-severe mental health conditions (up to 20 visits per calendar year combined with chemical dependency visits) ⁹	\$35/visit ² (\$50/visit ² if provider is MHSA Access+ Specialist provider) ³ ●	\$20/visit ² (\$35/visit ² if provider is MHSA Access+ Specialist provider) ³ ●
Chemical dependency services (substance abuse) ⁸		
Inpatient hospital facility services for medical acute detoxification	40%/admit	\$250/admit
Outpatient visits (up to 20 visits per calendar year combined with non-severe mental health visits) ⁹	\$35/visit ² (\$50/visit ² if provider is MHSA Access+ Specialist provider) ³ ●	\$20/visit ² (\$35/visit ² if provider is MHSA Access+ Specialist provider) ³ ●
Home health services (up to 100 visits per calendar year)		
Home health agency visits (up to 4 visits per day, 2 hours per visit)	\$35 ●	\$20 ●
Other		
Pregnancy and maternity care¹⁰		
Outpatient prenatal and postnatal physician office visits	\$35/visit ●	\$20/visit ●
Delivery and all necessary inpatient hospital services	40%/admit	\$250/admit
Family planning		
Counseling	\$35/visit ●	\$20/visit ●
Tubal ligation, ¹¹ elective abortion	\$100/occurrence ●	\$100/occurrence ●
Vasectomy	\$75/occurrence ●	\$75/occurrence ●
Rehabilitation services – physical, occupational and respiratory therapy		
Received in a physician's office visit or in hospital outpatient department	\$35/visit ●	\$20/visit ●
In inpatient rehabilitation unit of hospital	40%/admit	\$250/admit
Urgent care (outside your plan service area) ¹²	\$50/visit ●	\$50/visit ●
Dental services (for details please see the Dental Highlights Matrix, page 40)		
Access+ Dentist	Not covered	Included within this plan



HMO plan footnotes

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

- Plan benefits provided before you need to meet the medical deductible.
- 1 Access+ HMO and Access+ Value HMO benefits are provided only for services that are medically necessary, as determined by the Personal Physician or Access+ Value HMO/Access+ HMO, except in an emergency or as otherwise specified, and must be received while the patient is a current member.
- 2 These copayments do not accrue to the copayment maximum.
- 3 To use the Access+ *Specialist* option, for other than mental health or chemical dependency 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 chemical dependency care, will accrue toward the 20-visit-per-calendar-year maximum. In addition, all Access+ *Specialist* visits require a copayment per visit. Mental health and chemical dependency Access+ *Specialist* visits are accessed through the MHSA utilizing MHSA participating providers.
- 4 Participating ambulatory surgery centers (ASCs) may not be available in all areas. Regardless of their availability, you can obtain outpatient surgery services from a hospital, or an ASC affiliated with a hospital with payment according to your health plan's hospital services benefits.
- 5 Only medically necessary outpatient formulary drugs are covered, unless prior authorization is obtained from Blue Shield Pharmacy Services. Non-formulary drugs may be covered only if prior authorization is obtained from Blue Shield Pharmacy Services. After all necessary documentation is available from your physician, prior authorization approval or denial will be provided to your physician within two working days of the request. Member is then responsible for the brand prescription copayment. Prescription coverage differs for home self-injectables. Please review the EOC before you purchase the plan.
- 6 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.
- 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 Blue Shield of California has contracted with a specialized healthcare service plan to act as the plan's mental health services administrator (MHSA) and to provide mental health and chemical dependency 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 (not MHSA) providers. For all other mental health and chemical dependency services, members should access MHSA participating providers.
- 9 For MHSA participating providers, initial visit treated as if the condition were a severe mental illness or serious emotional disturbance of a child. For MHSA non-participating providers, initial visit treated as an MHSA participating provider.
- 10 Except for the treatment of involuntary complications of pregnancy, pregnancy/maternity benefits for a pregnancy that qualifies as a waived condition are not available during the six-month period beginning as of the effective date of coverage.
- 11 The tubal ligation copayment does not apply when the procedure is performed in conjunction with delivery or abdominal surgery.
- 12 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. After all necessary documentation is available from your physician, prior authorization approval or denial will be provided to your physician within two working days of the request.

Additional services for no added cost

We believe staying well is just as important as getting well. That's why we offer a wide selection of programs, services, information and tools to better support your health.

Without any extra cost or paperwork, these convenient member services are available to you automatically:

NurseHelp 24/7SM – Registered nurses offer reliable information (by telephone or online) about:

- Treating minor illnesses and injuries
- Choosing the most appropriate type of health care
- Medical tests and medications
- Preventive care

LifeReferrals 24/7SM – Experienced professionals offer:

- Support with relationship issues
- Help finding a balance between career and personal life
- Referrals to senior care, child care, family, and relationship services
- Financial counseling and legal advice

Pre-Surgical Guided Imagery Program

Guided imagery can help reduce anxiety you might have before surgery and possibly help the speed of recovery. Members can order guided imagery audiotapes and CDs from Blue Shield.

Chart Your Course Diabetes Management Program

Members can access information and tools, such as screening test reminders, to help them manage their diabetes.

Discount Vision Program*

When you use MESVision providers in the Discount Vision Program¹, you will receive a 20% discount off the published retail prices on the following services and supplies:

- Routine eye examinations
- Frames and lenses
- Photochromic lenses
- Tints and coatings

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 with discounts 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 simply by presenting their Blue Shield ID card to any *Mylifepath* network practitioner and pay at least 25% off the practitioner's usual published fee for certain services.

* Note: Services that are excluded from this program include, but aren't limited to, disposable and replacement contact lenses, repairs for eyeglass frames, promotional eyecare offers, and medical/surgical treatment of the eyes and related services or supplies.

** The *Mylifepath* Alternative Care Discount Program is an exclusive offer to Blue Shield members, made available through an arrangement with American Specialty Health Networks (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 health plans apply. Blue Shield of California and ASH Networks do not review the program's practitioner services and products for medical necessity or efficacy, and make no representations, claims, or guarantees regarding their services or products. Members who use the discount program are responsible for the payment of services provided by participating network practitioners, including payment for cancelled or missed appointments. Members who are not satisfied with services received from the program's practitioners may use the Blue Shield grievance process. Blue Shield reserves the right to terminate this program without notice.

¹ Discount program services are provided by MESVision. MESVision network practitioners are screened, credentialed, and managed by MESVision. The MESVision 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. Members who are not satisfied with services received from the program's practitioners may use the Blue Shield grievance process.



blueshieldca.com

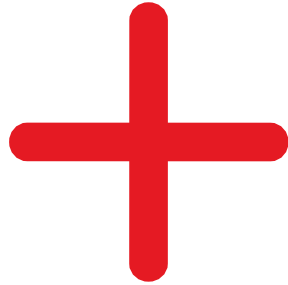
Our innovative Web site offers you valuable tools and reliable information to help you manage your health plan benefits. Once you become a member and register on **blueshieldca.com**, you'll have access to:

- **My Health Plan:** Find out about your specific plan's benefits and services, view summaries of copayments, coinsurance, and annual deductible amounts.
- **Lifepath Decision Guide:**SM Compare inpatient services and their costs at hospitals in your area. Also find out about the treatment options for a diagnosed condition.
- **Find a Provider:** Find physicians, dentists, optometrists, chiropractors, hospitals, clinics, and other healthcare providers. Search by name, specialty, gender, location, or medical group and even print directions.
- **Pharmacy:** Send your questions about prescriptions and over-the-counter drugs to a pharmacist at the University of California, San Francisco, and receive an answer within two business days. Check for drugs listed in the formulary. Compare the copayments of generic versus brand-name drugs and research drug interactions. Find a participating pharmacy near you.
- **Health & Wellness:** Search our Health Library for up-to-date information on a wide variety of health topics from expert health sources. And discover helpful health topics delivered right to your inbox by subscribing to our *Health Update* e-newsletter.

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 diabetes.

Tip: For more information about our health programs or publications, call us at **(800) 431-2809** or visit the *Health and Wellness* section of **blueshieldca.com**.



additional
coverage



Dental coverage

Complete your Blue Shield health coverage with our affordable dental plans.

Dental coverage

Because dental health is an important part of your total wellness, we offer affordable HMO and PPO 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.

Blue Shield Dental

PPO		HMO	
Choose any dental provider. Out-of-pocket costs for covered services are lowest when you receive care from network dentists.		Choose a dental care provider from our dental HMO provider network to provide all of your family's network dental care.	
	Monthly rate		Monthly rate
Subscriber	\$35	Subscriber	\$17
Subscriber and spouse	\$74	Subscriber and spouse	\$34
Subscriber and child	\$53	Subscriber and child	\$30
Subscriber and children	\$79	Subscriber and children	\$35
Family	\$123	Family	\$66
Plan features:		Plan features:	
<ul style="list-style-type: none"> • Access to over 19,000 general care and specialty dentists in California* • Coverage when using a non-network dentists • Fixed copayments in network • Calendar-year deductible of \$50 per member • Calendar-year benefit maximum of \$1,000 per member • Wide range of dental benefits, with most diagnostic and preventive services fully covered when using network providers • Orthodontic benefits for children and adults • No waiting period, after enrollment, for diagnostic or preventive services • Enhanced dental benefits for pregnant women 		<ul style="list-style-type: none"> • Access to over 8,600 dental provider locations in California* • No calendar-year maximums • Fixed copayments and no deductibles • Wide range of dental benefits, including most diagnostic and preventive services at no out-of-pocket cost to you • Specialty care available with referral from your dental provider • Orthodontic benefits for children and adults • No waiting period for any type of service, other than orthodontics • Practically no claims forms 	

* Dental providers in California are contracted through Dental Benefit Providers of California.

Please note: Monthly rates for the dental HMO and dental PPO plans are in addition to the monthly rates 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 HMO medical plan, your dental HMO plan and health coverage effective dates must be the first of the month. (No benefits are paid for services received before the effective date.) If you select the PPO medical plan along with a dental HMO or dental PPO plan, you may request any effective date for both plans.

Dental PPO and dental HMO plan benefits supersedes Access+ Dentist and EssentialSM plans' dental benefits. If you're an Access+ HMO or Essential plan member who purchases the dental PPO or dental HMO plan, you receive the more generous benefits of the plan you have chosen and will not receive any of the dental benefits of Access+ Dentist or the Essential plan.

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		Dental HMO ^{3,4}	Access+ Dentist
	With network dentists, you pay:	With non-network 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 composite (filling)	\$37	\$30	\$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 pontic/false tooth - high noble metal (per unit)	\$293	\$234	\$300*	80%**
Bridge retainer - porcelain fused to high noble metal (per unit)	\$313	\$250	\$300*	80%**
Complete denture (upper or lower)	\$388	\$310	\$400	80%**
Oral surgery²				
Extraction (single tooth)	\$40	\$32	\$34	80%**
Removal of impacted tooth (complete bony)	\$113	\$90	\$125	Not covered
Enhanced dental services for pregnant women⁷ (not subject to plan deductibles with network dentists)	\$0	100% of charge	Not covered	Not covered
Orthodontics^{2,4,8}				
Fully banded (2-year) case – child	\$2,350***	Not covered	\$2,350***	Not covered
Fully banded (2-year) case – adult	\$2,650***	Not covered	\$2,650***	Not covered

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

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

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

- 1 Use any network 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; 12 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 dentist, chosen from the Blue Shield Dental HMO Dental Provider Directory. If you need to see a specialist, you must get a referral from your dental provider 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 Services 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 One additional routine adult prophylaxis (including periodontal prophylaxis for gingivitis) for women during pregnancy and one periodontal maintenance visit if warranted by a history of periodontal treatment and one course (up to four quadrants) of periodontal scaling and root planing for women during pregnancy with a documented existing periodontal condition.
- 8 Orthodontic services have a fixed patient copayment and do not apply to your \$1,000 in-network plan maximum.



Life insurance

Individual term life insurance* coverage

Protect your family when they need it most. Whether it's to contribute toward mortgage payments or a child's education, or to provide financial support in uncertain times, Blue Shield Life can help you prepare for the unexpected or unknown. We offer the financial protection and security of \$10,000, \$30,000, \$60,000 or \$90,000 in term life insurance.

Individual term life insurance is available to primary subscribers (ages 1 to 64) of any Blue Shield health plan for individuals and families, including YouthCare subscribers, except those members of Blue Shield guaranteed-issue plans.

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

Monthly individual term life insurance rates

Amount of insurance

Age range	\$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 younger than 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 ages 50 years or older, but current members who turn age 50 are eligible to keep their coverage until age 65.

It's easy to enroll

Applying for dental or term life insurance coverage couldn't be easier. Just complete the dental and/or life insurance part of your Blue Shield health plan application. If coverage is approved your health plan, dental and/or life insurance effective dates will be the same, and you'll receive a single combined monthly bill.

If you are signing up for the Blue Shield dental HMO, please be sure to list a dental provider for yourself and your family on your application. If you do not have a copy of Blue Shield's Dental HMO Dental Provider Directory, please visit the *Find a Provider* section of [blueshieldca.com](https://www.blueshieldca.com) or call **(800) 431-2809**.

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 Insurability form by calling us at (800) 431-2809, or download it from [blueshieldca.com](https://www.blueshieldca.com). If coverage is approved, your life insurance effective date will be the first day of the month following approval.

