

choosing your health plan

Effective February 1, 2007

we can help

Choosing a health plan can be confusing, but this booklet can help you understand, choose and use the coverage that's right for you. Inside you'll find information about what health coverage is, why you need it, and how it works. You'll also find detailed descriptions of our health plans to help you compare plans and select the one that best meets your 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 as soon as 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, be sure to read this booklet and the EOC/Policy before you apply for coverage, to find out if the services you need are covered. To review the Uniform Health Plan Benefits and Coverage Matrix (Uniform Matrix) for individual plans, please refer to the Table of Contents.

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

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finding the right plan

Protect your well-being today

Having quality healthcare coverage matters. It's also important to have a plan that fits your lifestyle, so that you're protected but aren't paying for benefits you don't believe you'll need. With our wide range of affordable plans, we can meet your specific requirements and budget. And all of our plans provide easy access to:

- One 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

You can't afford not to have health coverage

Health coverage helps protect you physically *and* financially. With a Blue Shield plan, you'll pay only a fraction of the total cost of your medical care because of the specific amounts our network providers have agreed to charge Blue Shield for their services. And you'll have access to one of the largest networks of doctors and hospitals in California, so it's easy to find the doctor you want.

If you're injured in a serious accident, you could incur some very large medical bills. The example in the chart below compares your healthcare costs if you're uninsured to your costs as a Blue Shield member. The expenses shown include:

- Ground ambulance service
- Trauma-related ER services
- Treatment for a broken arm and leg
- Surgery for internal injuries
- Five days in a semi-private hospital room
- Pain reducers, antibiotics (a five-day supply of a generic prescription)
- Physical therapy for six weeks
- A non-power wheelchair rental or standard crutches

Tip: With a Blue Shield plan, you'll pay only a fraction of the total cost of your medical care because of the specific amounts our network providers have agreed to charge Blue Shield for their services.



In this case, your hospital bill would be \$140,185 without insurance, compared to an average total cost of \$6,899 if you're covered with a Blue Shield plan – a savings of more than \$133,000. Since the doctors and hospitals in our networks have agreed to bill specific fees for their services (called "allowable amounts"), we can help protect you from the high costs you would be subject to without coverage.

Typical healthcare costs for a serious accident					
	Uninsured Billed Amount	Your Costs			
		Shield Spectrum PPO Plan 5000*	Shield Spectrum PPO Savings Plan 4000*	Access+ Value HMO	Active Start Plan 25*
Total medical costs including deductible	\$140,185	\$7,050	\$5,000	\$4,300	\$6,050
Annual total of monthly rates	N/A	\$1,128	\$996	\$2,628	\$1,776
Your total costs**	\$140,185	\$8,178	\$5,996	\$6,928	\$7,826
Your savings if you have health coverage	N/A	94%	97%	95%	94%

Please note: These costs are estimates based on 2006 examples of medical charges and monthly rates. Costs may vary depending on region and provider.

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

** Calculation assumes that any deductible has been met and you have not yet reached your annual coinsurance/copayment or out-of-pocket maximum.

How your health coverage works

You pay a set monthly rate for health plan coverage, and in return your plan pays for the majority of your medical costs once your medical deductible (as applicable to the plan) is met. You also pay a certain share of the cost for the medical care you receive. The size of your share depends on the specific plan, but in general, the higher the plan's monthly rate, the smaller the share of medical costs you pay before meeting your out-of-pocket maximum.

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

For quick explanations of these and other terms used in this booklet, see below. These explanations can help you choose a plan. For the actual definitions of terms, see the EOC/Policy.

Allowable amount – The Blue Shield allowance for covered service(s) rendered, or the provider's billed charge, whichever is less (as defined in the EOC/Policy). The Blue Shield of California or Blue Shield Life allowance for a participating provider is the amount that the provider and Blue Shield have agreed by contract will be accepted as payment in full for services rendered.

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 portion of the allowable amount that members pay for covered services when receiving benefits. It is the percentage amount that represents the member's share of the cost of covered services. So if a medical service, such as an ambulance ride, has an allowable amount of \$100 and your coinsurance amount is 20 percent, you would pay \$20 and your health plan would pay \$80. (Note that your plan may not pay for some services until after you meet your deductible.)

Copayment (or copay) – The portion of the allowable amount that members pay for covered services when receiving benefits. The fixed dollar amount that represents the member's share of the cost of covered services. If your office visit copayment is \$20, you would pay that amount each time you see your doctor. (Note that your plan 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, not including the plan deductible. Once you reach the maximum, Blue Shield will pay 100 percent of the allowable amount for all applicable covered services for the remainder of the calendar year, up to specified maximums. Copayments for certain PPO plan covered services, such as office visits, generally do not count toward these maximums, and these continue to be the member's responsibility.

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. If your health plan has a \$1,000 deductible, the plan pays all costs except your copayment/coinsurance for care after you pay for the first \$1,000 of your covered treatment costs. (Note: For some covered services, such as preventive care, your plan may pay for the treatment right away, 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 towards 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 accrue towards 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 amount you may have to pay for many covered services in a calendar year, including the deductible. Once you reach the maximum, Blue Shield will pay 100 percent of the allowable amount for all applicable covered services for the rest of the calendar year, up to specified maximums. Copayments for certain PPO plan covered services, such as office visits, generally do not count toward these maximums, so you will still be responsible for paying them after you reach the maximum.

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. PPO plan members don't have Personal Physicians and can see doctors without a referral.

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.

Quick answers

Here are answers to some common 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 by going to the *Find a Provider* area of 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.

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*. Also check the specific plan information in this booklet to see the details of a plan's prescription coverage, such as whether or not that plan covers brand-name drugs. You can also check the plan's EOC or Policy, or call **(800) 431-2809**.

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.

With an HMO plan, you:

- Receive many covered services for a fixed copayment
- Choose a designated Personal Physician from our HMO network who provides, refers, and coordinates your medical care
- Receive all medical services from providers in your Personal Physician's medical group or IPA (Independent Practice Association)
- Can go directly to an Access+ *Specialist*SM without a referral
- Must live or work in the HMO service area (identified in our HMO directory)
- Generally pay higher monthly rates so that your costs are lower whenever you access care throughout the year

With a PPO plan, you:

- Choose your own doctor(s) each time you seek medical care
- Generally pay lower monthly rates in exchange for higher out-of-pocket costs when you access care throughout the year
- Receive some preventive care benefits even before you meet your plan deductible
- Pay a percentage of charges for most covered services after you meet your plan deductible
- Reduce your out-of-pocket costs when you use our preferred provider network, which includes more than 350 hospitals and over 45,000 doctors

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

Here are some basic differences. Please see pages 10-35 for a description of all your PPO plan choices and review each plan's benefit summary for more detail.

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



Tip: In general, the higher the calendar-year deductible for a PPO plan, the lower the monthly rates.

How do deductibles work?

If your health plan has a deductible, you must pay this amount each year before Blue Shield makes payments towards covered services. Depending on your plan, some services, such as preventive care, may be covered by Blue Shield before you meet your deductible. See your EOC/Policy for more details.

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 towards the family deductible, and once the family deductible is met, the 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 meeting any deductible. 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 some families' health coverage needs to place family members on different types of plans. You may save money by putting your child on his or her own plan with special YouthCareSM rates instead of having a single family plan. For more information about this option, contact your agent or call us at **(800) 431-2809**.

Can I get dental coverage through Blue Shield?

Yes. If you're a Blue Shield member, you can enroll in the Dental PPO or Dental HMO plan for an additional cost. In addition, dental coverage is included at no extra charge, with our EssentialSM plans* and Access+ HMO[®] plan. Please see pages 44-46 for details.

Can I get life insurance through Blue Shield?

Yes. If you are approved for a health plan, you can purchase term life insurance through Blue Shield of California Life & Health Insurance Company without a separate approval process. Please see page 47 for more details.

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

Which plan is right for you?

Whatever your situation, we have coverage that fits. Use the following chart to help you identify which plans may best fit your needs.

If you:	Then we recommend the following plans:
Want our lowest monthly rate, infrequently go to the doctor and want coverage in case of a major medical event.	Shield Spectrum PPO Savings Plan 4000 [†] Shield Spectrum PPO Plan 5000 [†]
See your doctor now and then and want affordable monthly rates. You prefer brand name drugs instead of generics.	Active Start Plans [†] Balance Plans [†]
Want an affordable monthly rate with medical, dental and vision coverage all in one plan.	Essential Plans [†]
Want a plan that is compatible with a Health Savings Account (HSA).	Shield Spectrum PPO Savings Plans
Plan on having a baby in the next few years.	Shield Spectrum PPO Plan 2000 [†] Shield Spectrum PPO Savings Plan 2400 Access+ HMO
Need a plan for your child.	YouthCare Rates: Active Start Plans [†] Balance Plan 1000 [†] Access+ Value HMO
Are over 55 and need coverage until you get Medicare.	Shield Spectrum PPO Plan 5000 [†] Shield Spectrum PPO Savings Plan 4000 [†] Essential Plan 4500 [†]

[†] Underwritten by Blue Shield of California Life & Health Insurance Company. Blue Shield and Blue Shield Life both offer a PPO plan 2000.

The chart below shows the features of our different plan families, to help you determine what benefits you need and decide which plan family may work best.

Features	Active Start Plans*	Essential Plans*	Balance Plans*	Shield Spectrum PPO Savings Plans*	Shield Spectrum PPO Plans*	HMO Plans
Individual only coverage	•	•				
Coverage for Couples or Families			•	•	•	•
No medical deductible	•					
Preventive care not subject to the deductible	n/a	•	•	•	•	•
HSA-compatible				•		
Chiropractic coverage	•		•	•	PPOs 500-2000 plans only	
Acupuncture coverage	•		•			
Maternity coverage				PPO Savings Plan 2400/4800 only	•	•
Dental benefits		•				Access+ HMO only
Vision benefits		•				
Brand-name prescription coverage	•		•	•	•	•

* Active Start plans, Essential plans, Balance plans, PPO Savings Plan 4000/8000 and PPOs 1500, 2000 and 5000 are underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life). Blue Shield and Blue Shield Life each offer a PPO 1500 and 2000. Essential plan 1750, Balance plans 1000, 1700 and 2500 are subject to regulatory approval.

Plan comparison chart

← Available plans → ← Health plan features → ← Your copayments →

	Annual medical deductible	Total calendar-year out-of-pocket costs	Preventive care	
		With preferred providers, includes plan deductible ²	Annual physical, well-baby care, gynecological exam	Pap test, screening adult im
PPO plans				
● Essential SM Plan 4500 [†]	\$4,500 individual	● \$4,500 individual copayment maximum	● \$40	● Covered as per
● Essential SM Plan 3000 [†]	\$3,000 individual	● \$3,000 individual copayment maximum	● \$40	● Covered as per
● New! Essential SM Plan 1750 [†]	\$1,750 individual	● \$1,750 individual copayment maximum	● \$40	● Covered as per
● Active Start SM Plan 35 [†]	No individual deductible	\$7,500 individual copayment maximum	● \$35	● Covered as per
● Active Start SM Plan 25 [†]	No individual deductible	\$6,000 individual copayment maximum	● \$25	● Covered as per
New! Balance SM Plan 2500 [†]	\$2,500 individual \$5,000 family	● \$7,500 (\$15,000 family) copayment maximum	● \$30	● Covered as per
New! Balance SM Plan 1700 [†]	\$1,700 individual \$3,400 family	● \$6,500 (\$13,000 family) copayment maximum	● \$30	● Covered as per
New! Balance SM Plan 1000 [†]	\$1,000 individual \$2,000 family	● \$5,500 (\$11,000 family) copayment maximum	● \$30	● Covered as per
Shield Spectrum PPO SM 5000 [†]	\$5,000 individual \$10,000 family	● \$7,000 (\$14,000 family) copayment maximum	● \$35	● Covered as per
Shield Spectrum PPO SM 2000 [†]	\$2,000 individual \$4,000 family	\$5,000 (\$10,000 family) copayment maximum + deductible = \$7,000 (\$14,000 family) out-of-pocket costs	● \$45	● Covered as per
Shield Spectrum PPO SM 1500 [†]	\$1,500 individual \$3,000 family	\$4,500 (\$9,000 family) copayment maximum + deductible = \$6,000 (\$12,000 family) out-of-pocket costs	● \$40	● Covered as per
Shield Spectrum PPO SM 750	\$750 individual \$1,500 family	\$4,000 (\$8,000 family) copayment maximum + deductible = \$4,750 (\$9,500 family) out-of-pocket costs	● \$35	● Covered as per
Shield Spectrum PPO SM 500	\$500 individual \$1,000 family	\$3,500 (\$7,000 family) copayment maximum + deductible = \$4,000 (\$8,000 family) out-of-pocket costs	● \$30	● Covered as per
● Shield Spectrum PPO SM Savings Plan 4000/8000 [†]	\$4,000 individual \$8,000 family [#]	● \$4,000 (\$8,000 family) out-of-pocket maximum	● ● \$35	● ● 30%
● Shield Spectrum PPO SM Savings Plan 2400/4800	\$2,400 individual \$4,800 family [#]	● \$3,200 (\$5,800 family) out-of-pocket maximum	● \$35	● 30%
HMO plans				
Access+ Value HMO SM	\$2,000 individual ¹ \$4,000 family ¹	● \$4,000 (\$8,000 family) copayment maximum	● \$35	● ● \$35
Access+ HMO [®]	\$2,000 individual ¹ \$4,000 family ¹	● \$3,000 (\$6,000 family) copayment maximum	● \$20	● ● \$20

key:

- Benefits are provided right away, before you have to meet any plan deductible. You are responsible for all charges up to the allowable amount until the deductible is met. At that point, you will be responsible for the copayment or coinsurance noted in the chart when accessing preferred providers.
- Individual only plans
- HSA compatible plans
- Annual deductible accrues to the copayment maximum
- No charge once deductible is met
- No charge for pediatric/adult immunizations

Cost-sharing/coinsurance responsibility

	Professional services	Hospital services		Outpatient services		ER services
	Physician office visits	Hospital inpatient (non-emergency)	Maternity services (resulting in delivery)	Surgery (in hospital)	X-ray and laboratory	ER visits
...t, approved cervical cancer ...ng, mammography, pediatric/ ...munizations						
...red by the copay when performed ...rt of the preventive care visit	●● \$40 ⁴	● No charge after deductible	Not covered	● No charge after deductible	● No charge after deductible	● \$100 ³
...red by the copay when performed ...rt of the preventive care visit	●● \$40 ⁴	● No charge after deductible	Not covered	● No charge after deductible	● No charge after deductible	● \$100 ³
...red by the copay when performed ...rt of the preventive care visit	●● \$40 ⁴	● No charge after deductible	Not covered	● No charge after deductible	● No charge after deductible	● \$100 ³
...red by the copay when performed ...rt of the preventive care visit	● \$35	● \$500/admit + 40%	Not covered	● \$500/visit + 40%	● 40%	● \$35 ³ + 40%
...red by the copay when performed ...rt of the preventive care visit	● \$25	● \$500/admit + 40%	Not covered	● \$500/visit + 40%	● 40%	● \$25 ³ + 40%
...red by the copay when performed ...rt of the preventive care visit	● \$30	30%	Not covered	\$250/visit + 30%	30%	● \$100 ³ + 30%
...red by the copay when performed ...rt of the preventive care visit	● \$30	30%	Not covered	\$250/visit + 30%	30%	● \$100 ³ + 30%
...red by the copay when performed ...rt of the preventive care visit	● \$30	30%	Not covered	\$250/visit + 30%	30%	● \$100 ³ + 30%
...red by the copay when performed ...rt of the preventive care visit	\$35	30%	30%	30%	30%	30%
...red by the copay when performed ...rt of the preventive care visit	● \$45	\$250/admit + 30%	\$250/admit + 30%	\$250/visit + 30%	30%	\$100 ³ + 30%
...red by the copay when performed ...rt of the preventive care visit	● \$40	\$250/admit + 30%	\$250/admit + 30%	\$250/visit + 30%	30%	\$100 ³ + 30%
...red by the copay when performed ...rt of the preventive care visit	● \$35	\$250/admit + 30%	\$250/admit + 30%	\$250/visit + 30%	30%	\$100 ³ + 30%
...red by the copay when performed ...rt of the preventive care visit	● \$30	\$250/admit + 25%	\$250/admit + 25%	\$250/visit + 25%	25%	\$100 ³ + 25%
...	● No charge after deductible	● No charge after deductible	Not covered	● No charge after deductible	● No charge after deductible	● No charge after deductible
...	30%	30%	30%	30%	30%	\$75 ³ + 30%
...	● \$35	40%/admit	40%/admit	40%/visit	● \$35/visit	● \$150 ³
...	● \$20	\$250/admit	\$250/admit	\$250/visit	● \$20/visit	● \$75 ³

Prescription benefits				
Ambulance	ER physician visits/consultations	Generic	Brand-name drugs (formulary)	Brand-name drugs (non-formulary)
● No charge after deductible	● No charge after deductible	● \$10/Rx	Not covered	Not covered
● No charge after deductible	● No charge after deductible	● \$10/Rx	Not covered	Not covered
● No charge after deductible	● No charge after deductible	● \$10/Rx	Not covered	Not covered
● 40%	● \$35	● \$10/Rx	\$35/Rx (after \$750 brand-name deductible)	\$50 or 50% (whichever is greater)/Rx (after \$750 brand-name deductible)
● 40%	● \$25	● \$10/Rx	\$35/Rx (after \$500 brand-name deductible)	\$50 or 50% (whichever is greater)/Rx (after \$500 brand-name deductible)
30%	30%	● \$10/Rx	\$35/Rx (after \$500 brand-name deductible)	\$50 or 50%, whichever is greater/Rx (after \$500 brand-name deductible)
30%	30%	● \$10/Rx	\$35/Rx (after \$500 brand-name deductible)	\$50 or 50%, whichever is greater/Rx (after \$500 brand-name deductible)
30%	30%	● \$10/Rx	\$35/Rx (after \$500 brand-name deductible)	\$50 or 50%, whichever is greater/Rx (after \$500 brand-name deductible)
30%	30%	● \$10/Rx	\$35/Rx (after \$500 brand-name deductible)	\$50 or 50% (whichever is greater)/Rx (after \$500 brand-name deductible)
30%	30%	● \$10/Rx	\$35/Rx (after \$500 brand-name deductible)	\$50 or 50%, whichever is greater (\$150 max)/Rx (after \$500 brand-name deductible)
30%	30%	● \$10/Rx	\$35/Rx (after \$500 brand-name deductible)	\$50 or 50%, whichever is greater (\$150 max)/Rx (after \$500 brand-name deductible)
30%	30%	● \$10/Rx	\$35/Rx (after \$250 brand-name deductible)	\$50 or 50%, whichever is greater (\$150 max)/Rx (after \$250 brand-name deductible)
25%	25%	● \$10/Rx	\$35/Rx (after \$250 brand-name deductible)	\$50 or 50%, whichever is greater (\$150 max)/Rx (after \$250 brand-name deductible)
● No charge after deductible	● No charge after deductible	You will receive Blue Shield's contracted rate at participating pharmacies. After meeting the medical deductible there will be no charge at participating and non-participating pharmacies. ⁵		
30%	30%	You will receive Blue Shield's contracted rate at participating pharmacies. After meeting the medical deductible, you will pay 30% at participating and non-participating pharmacies. ⁵		
● \$50	● No charge	● \$10/Rx	\$35/Rx (after \$400 brand-name deductible)	Not covered (except with prior authorization)
● \$50	● No charge	● \$10/Rx	\$35/Rx (after \$200 brand-name deductible)	Not covered (except with prior authorization)

Please note: Member can receive a free transfer to our Shield Spectrum PPO Plan 5000[†] from any of our non-maternity plans if the member becomes pregnant.

plan comparison chart footnotes:

The Plan Comparison Chart shows copayment/coinsurance amounts you will pay for covered services received from participating providers only.

[†] Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life). Blue Shield of California and Blue Shield Life each offer a PPO 1500 and 2000 plan. The \$150 max/Rx for non-formulary brand-name drugs does not apply to Blue Shield Life Shield Spectrum PPO Plans 2000 or 1500. Please call **(800) 431-2809** for more information.

No individuals will be eligible for benefits until after the family deductible is met.

1 For Access+ HMO and Access+ Value HMO plans, the deductible applies only to facility charges for inpatient hospital services, outpatient hospital surgery services, skilled nursing facility services, hospice program services, and ambulatory surgery center services.

2 For certain plans, copayments made for some services may not count towards the out-of-pocket or copayment maximum.

3 The initial flat-dollar emergency room copayment is waived if you are admitted directly to the hospital as an inpatient.

4 Limited to first 3 visits per calendar year. Subsequent visits are subject to the deductible.

5 Member pays full price and submits prescription drug claims to Blue Shield.

Essential Plan 1750 and Balance Plans 1000, 1700, and 2500 are subject to regulatory approval.

This information is intended only as a brief comparison of some of the benefits of the various Blue Shield plans.

This document is not a contract. You should request and review the *Evidence of Coverage and Health Service Agreement/Policy for Individuals and Families* for a more complete description of the benefits, terms, conditions and limitations of the health plans.

understanding
plan benefits

Essential plans

Underwritten by Blue Shield of California Life & Health Insurance Company

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.

EssentialSM plans limit the total annual amount you may have to spend on copayments and deductibles, and include dental and vision coverage at no added cost.

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 percent after the deductible is met.
- Affordable copayments for preventive care office visits (\$40) and generic prescription drugs at network pharmacies (\$10).
- One of the largest PPO provider networks in California, so it's easy to find the doctor you want.
- LASIK discount program.*
- Choice of three annual deductibles (\$1750, \$3000, and \$4500).
- Knowledgeable customer service representatives who can assist you and quickly answer your questions.

* This discount program is not a benefit of the plan and is offered in addition to the benefits covered under the plan. Members who are not satisfied with services received under the discount program may use the Blue Shield Life grievance process. Blue Shield reserves the right to terminate this program without notice.

Essential plans:

- Essential plan 1750
- Essential plan 3000
- Essential plan 4500



Is an Essential plan right for you?

You know you need coverage for predictable – and unpredictable – events, but you don't want to spend a lot on monthly rates. Our Essential plans provide the affordable quality coverage you need and limit your possible out-of-pocket costs. The plans are available for individuals only and don't include maternity care and brand-name drug benefits. If you become pregnant as a member on an Essential plan, Blue Shield offers a free transfer to our Shield Spectrum PPO Plan 5000.†

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

Essential plans 1750, 3000, and 4500

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 should be consulted for a detailed description of coverage benefits and limitations.

	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 <small>(includes the plan deductible – some services do not apply)</small>	Services with preferred providers: \$1,750 Individual only Services with all providers: \$3,500	Services with preferred providers: \$3,000 Individual only Services with all providers: \$5,000	Services with preferred providers: \$4,500 Individual only Services with all providers: \$6,500
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 colored 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 <small>(Subject to the plan deductible unless noted)</small>	Member copayments			
	With preferred providers, ¹ you pay			With non-preferred providers, ¹ you pay
	Essential Plan 1750	Essential Plan 3000	Essential Plan 4500	
Professional services				
Office visits (First 3 visits/calendar year – subsequent visits are subject to the deductible)	\$40 (no charge after deductible) ●	\$40 (no charge after 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 ●	\$40 ² ●	\$40 ² ●	Not covered
Outpatient services (The maximum allowed charges for non-emergency surgery and services performed in a non-participating Ambulatory Surgery Center is \$300 per day. Members are responsible for 50 percent of this \$300 per day, plus all charges in excess of \$300.)				
Non-emergency services and procedures	No charge after deductible	No charge after deductible	No charge after deductible	50% ^{2,3}
Outpatient surgery in hospital	No charge after deductible	No charge after deductible	No charge after deductible	50% ^{2,3}
Outpatient surgery performed in an Ambulatory Surgery Center (ASC) ⁴	No charge after deductible	No charge after deductible	No charge after deductible	50% ²
Outpatient or out-of-hospital X-ray and laboratory	No charge after deductible	No charge after deductible	No charge after deductible	50%

Essential plans 1750, 3000 and 4500

Covered services <small>(Subject to the plan deductible unless noted)</small>	Member copayments			
	With preferred providers, ¹ you pay			With non-preferred providers, ¹ you pay
	Essential Plan 1750	Essential Plan 3000	Essential Plan 4500	
Hospitalization services				
Inpatient physician visits and consultations, surgeons and assistants, and anesthesiologists	No charge after deductible	No charge after deductible	No charge after deductible	50%
Inpatient semiprivate room and board, services and supplies, and subacute care	No charge after deductible	No charge after deductible	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	No charge after deductible	No charge after deductible	50% ^{2,3}
Emergency health coverage				
Emergency room services (\$100 copayment waived if the member is admitted directly to the hospital as an inpatient)	\$100/visit ² ●	\$100/visit ² ●	\$100/visit ² ●	\$100/visit ² ●
ER physician visits	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Ambulance services (surface or air)				
	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Essential Plans 1750, 3000, and 4500				
Prescription drug coverage (outpatient)			At participating pharmacies <small>(up to a 30-day supply)</small>	Mail service prescriptions <small>(up to a 60-day supply)</small>
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
	Essential Plan 1750	Essential Plan 3000	Essential Plan 4500	
Durable medical equipment⁴	No charge after deductible	No charge after deductible	No charge after deductible	50%

continued on following page ...

Essential plans 1750, 3000 and 4500

Covered services <small>(Subject to the plan deductible unless noted)</small>	Member copayments			
	With MHSAs Participating providers, ^{1,7} you pay			With MHSAs non-Participating providers, ^{1,7} you pay
	Essential Plan 1750	Essential Plan 3000	Essential Plan 4500	
Mental health services				
Inpatient hospital facility services	No charge after deductible	No charge after deductible	No charge after deductible	50% ^{2,3}
Inpatient physician services	No charge after deductible	No charge after deductible	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) ●	\$40 (No charge after 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)	No charge after deductible ⁸	No charge after deductible ⁸	No charge after deductible ⁸	Not covered ⁸
Chemical dependency services (substance abuse)				
Inpatient hospital facility services for medical acute detoxification	No charge after deductible	No charge after deductible	No charge after deductible	50% ^{2,3}
Inpatient physician services for medical acute detoxification	No charge after deductible	No charge after deductible	No charge after deductible	50%
Outpatient visits (up to 20 visits per calendar year combined with non-severe mental health visits)	No charge after deductible ⁸	No charge after deductible ⁸	No charge after deductible ⁸	Not covered ⁸
	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 deductible	No charge after deductible	No charge after deductible	Not covered
Other				
Pregnancy and maternity care				
Outpatient prenatal and postnatal care	Not covered	Not covered	Not covered	Not covered
Delivery and all necessary inpatient hospital services	Not covered	Not covered	Not covered	Not covered
Family planning				
Consultations, tubal ligation, vasectomy, elective abortion	No charge after deductible	No charge after deductible	No charge after deductible	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, occupational, or respiratory therapist	No charge after deductible	No charge after deductible	No charge after deductible	50%

Essential plans 1750, 3000 and 4500

Covered services (Subject to the plan deductible unless noted)	Member copayments			
	With preferred providers, ¹ you pay			With non-preferred providers, ¹ you pay
Chiropractic services	Not covered	Not covered	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	No charge after deductible with BlueCard Participating providers	No charge after deductible with BlueCard Participating providers	50% with all other providers
Vision services⁹				
Vision exam	\$5 ² ●	\$5 ² ●	\$5 ² ●	\$5 ² ●

Dental services are NOT subject to the plan medical deductible, but there is a \$50 dental deductible for some minor restorative services

	Essential Plan 1750	Essential Plan 3000	Essential Plan 4500	
Dental services¹⁰				
Preventive and diagnostic (including routine oral exams, X-rays and cleaning)	No charge	No charge	No charge	All charges above the allowable amount
Minor restorative ² (Subject to \$50 dental deductible, including amalgam and resin based fillings)	\$35 - \$100 (depending on procedure)	\$35 - \$100 (depending on procedure)	\$35 - \$100 (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 ambulatory surgery centers may not be available in all areas. Regardless of their availability, you can obtain outpatient surgery services from a hospital, or an ambulatory surgery center affiliated with a hospital with payment according to your health plan's hospital services benefits.
- 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 was 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 exam 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.

Active Start plans:

- Active Start plan 25
- Active Start plan 35

Active Start plans

Underwritten by Blue Shield of California Life & Health Insurance Company

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

Our Active StartSM plans for individuals keep you covered in case of a serious medical event while also taking care of your day-to-day healthcare needs, for low monthly rates and no annual medical deductible.



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. If you become pregnant as a member on an Active Start plan, Blue Shield offers a free transfer to our Shield Spectrum PPO Plan 5000†

Active Start plan advantages

- Affordable coverage for individuals.
- One of California's largest PPO provider networks, so it's easy to find the doctor you want.
- You choose the low copayment that best fits your budget (\$25 or \$35).
- No medical deductible to meet, so your coverage starts immediately.
- Low \$25/\$35 copayments for preventive care office visits and \$10 copayments for generic prescription drugs at participating pharmacies.
- Benefits for alternative care such as chiropractic and acupuncture.
- Knowledgeable customer service representatives who can assist you and quickly answer your questions.

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



Active Start plans 25 and 35

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* should be consulted for a detailed description of coverage benefits and limitations.

	Active Start plan 25	Active Start plan 35
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 <small>(some services do not apply.)</small>	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.

Covered services	Member copayments		
	With preferred providers, ¹ you pay		With non-preferred providers, ¹ you pay
	Active Start Plan 25	Active Start Plan 35	
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 (The maximum allowed charges for non-emergency surgery and services performed in a non-participating Ambulatory Surgery Center is \$300 per day. Members are responsible for 50 percent of this \$300 per day, plus all charges in excess of \$300.)			
Non-emergency services and procedures	40%	40%	50% ^{2, 3}
Outpatient surgery in hospital	\$500/visit + 40%	\$500/visit + 40%	50% ^{2, 3}
Outpatient surgery performed in an Ambulatory Surgery Center (ASC) ⁴	40%	40%	50% ²
Outpatient or out-of-hospital X-ray and laboratory	40%	40%	50%
Hospitalization services			
Inpatient physician visits and consultations, surgeons and assistants, and anesthesiologists	40%	40%	50%
Inpatient semiprivate room and board, services and supplies, and subacute care	\$500/admit + 40%	\$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%	\$500/admit + 40%	50% ^{2, 3}

Active Start plans 25 and 35

Covered services	Member copayments		
	With preferred providers, ¹ you pay		With non-preferred providers, ¹ you pay
	Active Start Plan 25	Active Start Plan 35	
Emergency health coverage			
Emergency room services (\$25/\$35 copayment waived if the member is admitted directly to the hospital as an inpatient)	\$25/visit + 40%	\$35/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%	40%
Active Start Plan 25 and Active Start Plan 35			
Prescription drug coverage⁴ (outpatient – brand-name drugs are subject to a \$500/\$750 brand-name drug deductible per person, per calendar year)	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	
	With preferred providers, ¹ you pay		With non-preferred providers, ¹ you pay
	Active Start Plan 25	Active Start Plan 35	
Durable medical equipment⁷	40%	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%	\$500/admit + 40%	50% ^{2,3}
Inpatient physician services	40%	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)	40% ²	40% ²	Not covered
Chemical dependency services (substance abuse)			
Inpatient hospital facility services for medical acute detoxification	\$500/admit + 40%	\$500/admit + 40%	50% ^{2,3}
Inpatient physician services for medical acute detoxification	40%	40%	50%
Outpatient visits (up to 20 visits per calendar year combined with non-severe mental health visits)	40% ²	40% ²	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)	40%	40%	Not covered



Active Start plans 25 and 35

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

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

- 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 ambulatory surgery centers may not be available in all areas. Regardless of their availability, you can obtain outpatient surgery services from a hospital, or an ambulatory surgery center affiliated with a hospital with payment according to your health plan's hospital services benefits.
- 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. 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.

Balance plans:

- Balance plan 1000
- Balance plan 1700
- Balance plan 2500

Balance plans

Underwritten by Blue Shield of California Life & Health Insurance Company

New! These PPO plans balance coverage and cost, and offer a sensible blend of comprehensive benefits and relatively low deductibles.

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

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.

Balance plans 1000, 1700, and 2500

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.

	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 <small>(includes the plan deductible – some services do not apply.)</small>	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 colored 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 <small>(Subject to the plan deductible, unless noted)</small>	Member copayments			
	With preferred providers, ¹ you pay			With non-preferred providers, ¹ you pay
	Balance Plan 1000	Balance Plan 1700	Balance Plan 2500	
Professional services				
Office visits	\$30 ² ●	\$30 ² ●	\$30 ² ●	50%
Preventive care				
Annual routine physical exam, well-baby care office visits, and gynecological exam office visit <small>(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.)</small>	\$30 ² ●	\$30 ² ●	\$30 ² ●	Not covered
Outpatient services <small>(The maximum allowed charges for non-emergency surgery and services performed in a non-participating Ambulatory Surgery Center is \$300 per day. Members are responsible for 50 percent of this \$300 per day, plus all charges in excess of \$300.)</small>				
Non-emergency services and procedures	30%	30%	30%	50% ^{2,3}
Outpatient surgery in hospital	\$250/visit + 30%	\$250/visit + 30%	\$250/visit + 30%	50% ^{2,3}
Outpatient surgery performed in an Ambulatory Surgery Center (ASC) ⁴	30%	30%	30%	50% ²
Outpatient or out-of-hospital X-ray and laboratory	30%	30%	30%	50%

Balance plans 1000, 1700 and 2500

Covered services <small>(Subject to the plan deductible, unless noted)</small>	Member copayments			
	With preferred providers, ¹ you pay			With non-preferred providers, ¹ you pay
	Balance Plan 1000	Balance Plan 1700	Balance Plan 2500	
Hospitalization services				
Inpatient physician visits and consultations, surgeons and assistants, and anesthesiologists	30%	30%	30%	50%
Inpatient semiprivate room and board, services and supplies, and subacute care	30%	30%	30%	50% ^{2,3}
Bariatric surgery inpatient services (pre-authorization required: medically necessary surgery for weight loss, only for morbid obesity) ⁵	30%	30%	30%	50% ^{2,3}
Emergency health coverage				
Emergency room services (\$100 copayment waived if the member is admitted directly to the hospital as an inpatient)	\$100/visit + 30% ●	\$100/visit + 30% ●	\$100/visit + 30% ●	\$100/visit + 30% ●
ER physician visits	30%	30%	30%	30%
Ambulance services (surface or air)	30%	30%	30%	30%
Balance Plans 1000, 1700, and 2500				
Prescription drug coverage ⁶ (outpatient – brand-name drugs are subject to a \$500 brand-name drug deductible per person, per calendar year)	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	
	With preferred providers, ¹ you pay			With non-preferred providers, ¹ you pay
	Balance Plan 1000	Balance Plan 1700	Balance Plan 2500	
Durable medical equipment ⁷	30%	30%	30%	50%
	With MHSAs Participating providers, ^{1,8} you pay			With MHSAs non-Participating providers, ^{1,8} you pay
Mental health services				
Inpatient hospital facility services	30%	30%	30%	50% ^{2,3}
Inpatient physician services	30%	30%	30%	50%
Outpatient visits for severe mental health conditions	\$30 ² ●	\$30 ² ●	\$30 ² ●	50%
Outpatient visits for non-severe mental health conditions (up to 20 visits per calendar year combined with chemical dependency visits)	30% ⁹	30% ⁹	30% ⁹	Not covered ⁹
Chemical dependency services (substance abuse)				
Inpatient hospital facility services for medical acute detoxification	30%	30%	30%	50% ^{2,3}
Inpatient physician services for medical acute detoxification	30%	30%	30%	50%
Outpatient visits (up to 20 visits per calendar year combined with non-severe mental health visits)	30% ⁹	30% ⁹	30% ⁹	Not covered ⁹

Balance plans 1000, 1700 and 2500

Covered services <small>(Subject to the plan deductible, unless noted)</small>	Member copayments			
	With preferred providers, ¹ you pay			With non-preferred providers, ¹ you pay
	Balance Plan 1000	Balance Plan 1700	Balance Plan 2500	
Home health services (up to 90 pre-authorized visits per calendar year)	30%	30%	30%	Not covered
Other				
Pregnancy and maternity care				
Outpatient prenatal and postnatal care	Not covered	Not covered	Not covered	Not covered
Delivery and all necessary inpatient hospital services	Not covered	Not covered	Not covered	Not covered
Family planning				
Consultations, tubal ligation, vasectomy, elective abortion	30%	30%	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, occupational, or respiratory therapist	30%	30%	30%	50%
Chiropractic services (up to 15 visits per calendar year combined with acupuncture – Blue Shield's payment is limited to \$25)	50% ●	50% ●	50% ●	Not covered
Acupuncture (up to 15 visits per calendar year combined with acupuncture and chiropractic – Blue Shield's payment is limited to \$25)	50%	50%	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.

- 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/coinsurance 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 ambulatory surgery centers may not be available in all areas. Regardless of their availability, you can obtain outpatient surgery services from a hospital, or an ambulatory surgery center affiliated with a hospital with payment according to your health plan's hospital services benefits.
- 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 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.
- 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.
- 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 was 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 plans:

- PPO Plan 5000
- PPO Plan 2000
- PPO Plan 1500
- PPO Plan 750
- PPO Plan 500
- PPO Savings Plan 2400/4800
- PPO Savings Plan 4000/8000

Shield Spectrum PPO plans and Shield Spectrum PPO Savings Plans

Choose from a wide range of monthly rates, calendar-year deductibles, and benefits, including PPO plans that are HSA-compatible.

Shield Spectrum PPO Plans

These convenient plans make it easy to visit the doctors and specialists you want to see, and offer 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 less.

Shield Spectrum PPOSM Plan advantages

- One of California's largest PPO provider networks, so it's easy to find a doctor or hospital you want.
- Many services are covered before you meet the annual deductible.
- 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.
- 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 ProtectionSM* (CCP) with the PPO Plan 5000.*
- Knowledgeable customer service representatives who can assist you and quickly answer your questions.

Shield Spectrum PPO Savings Plans

These four high-deductible health plans are compatible with a Health Savings Account (HSA). They offer easy access to quality care and protection against major healthcare expenses, with the potential for tax savings.

Shield Spectrum PPOSM Savings Plan advantages

- Choose from a 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.
- One of the state's largest PPO networks, so it's easy to find doctors and hospitals.
- Get prescription drugs at our contracted rate at participating pharmacies.
- Convenient access to a mail service pharmacy benefit.
- 100% coverage for prescription drugs once you meet the out-of-pocket maximum.
- Once the family deductible is met, all remaining covered family members will have access to benefits. The family deductible can be met by any family member or combination of family members.
- Knowledgeable customer service representatives who can assist you and quickly answer your questions.

To learn more about the tax advantages of HSAs, talk to your tax advisor, or turn to page 40.

* *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

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.

Deductible*	\$5,000 (\$10,000 family)
Copayments	\$35 with preferred providers Not applicable with non-preferred providers
Coinsurance	30% with preferred hospitals 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 ProtectionSM	\$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 colored 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 (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	\$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 (The maximum allowed charges for non-emergency surgery and services performed in a non-participating Ambulatory Surgery Center is \$300 per day. Members are responsible for 50 percent of this \$300 per day, plus all charges in excess of \$300.)		
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}

Shield Spectrum PPO Plan 5000

Covered services	Member copayments	
	With preferred providers, ¹ you pay	With non-preferred providers, ¹ you pay
<i>(Subject to the plan deductible, unless noted)</i>		
Emergency health coverage		
Emergency room services	30%	30%
ER physician visits	30%	30%
Ambulance services (surface or air)	30%	30%
Prescription drug coverage⁴ (outpatient – brand-name drugs are subject to a \$500 brand-name drug deductible per person, per calendar year)	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
	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	\$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, occupational or respiratory 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



Shield Spectrum PPO Plan 5000 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 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 ambulatory surgery centers may not be available in all areas. Regardless of their availability, you can obtain outpatient surgery services from a hospital, or an ambulatory surgery center affiliated with a hospital with payment according to your health plan's hospital services benefits.
- 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 health care service plan to act as our mental health services administrator (MHSA). The MHSA provides mental health and chemical dependency services, other than inpatient services for medical acute detoxification, through a separate network of MHSA participating providers. Inpatient medical acute detoxification is a medical benefit provided by Blue Shield preferred or non-preferred (not MHSA) providers.

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.

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 (\$1000 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 Hospitals; 50% with Non-Preferred Providers	30% with Preferred Hospitals; 50% with Non-Preferred Providers	30% with Preferred Hospitals; 50% with Non-Preferred Providers	30% with Preferred Hospitals; 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 colored 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 (Subject to the plan deductible, unless noted)	Member copayments				With non-preferred providers, ¹ you pay
	With 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

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

Covered services <small>(Subject to the plan deductible, unless noted)</small>	Member copayments				
	With preferred providers, ¹ you pay				With non-preferred providers, ¹ you pay
	PPO 500	PPO 750	PPO 1500	PPO 2000	
Outpatient services (The maximum allowed charges for non-emergency surgery and services performed in a non-participating Ambulatory Surgery Center is \$300 per day. Members are responsible for 50 percent of this \$300 per day, plus all charges in excess of \$300.)					
Non-emergency services and procedures	25%	30%	30%	30%	50% ^{2,3}
Outpatient surgery in hospital	\$250/visit + 25%	\$250/visit + 30%	\$250/visit + 30%	\$250/visit + 30%	50% ^{2,3}
Outpatient surgery in performed in an Ambulatory Surgery Center (ASC) ⁴	25%	30%	30%	30%	50% ²
Outpatient or out-of-hospital X-ray and laboratory	25%	30%	30%	30%	50%
Hospitalization services					
Inpatient physician visits and consultations, surgeons and assistants, and anesthesiologists	25%	30%	30%	30%	50%
Inpatient semiprivate room and board, services and supplies, and subacute care	\$250/admit + 25%	\$250/admit + 30%	\$250/admit + 30%	\$250/admit + 30%	50% ^{2,3}
Bariatric surgery inpatient services (pre-authorization required: medically necessary surgery for weight loss, only for morbid obesity) ⁵	\$250/admit + 25%	\$250/admit + 30%	\$250/admit + 30%	\$250/admit + 30%	50% ^{2,3}
Emergency health coverage					
Emergency room services (\$100 waived if admitted as an inpatient)	\$100/visit + 25%	\$100/visit + 30%	\$100/visit + 30%	\$100/visit + 30%	Covered at same level as preferred providers
ER physician visits	25%	30%	30%	30%	Covered at same level as preferred providers
Ambulance services (surface or air)	25%	30%	30%	30%	Covered at same level as preferred providers
	For PPO Plans 500 to 2000				
Prescription drug coverage⁶ (outpatient – brand-name drugs are subject to a \$250/\$500 brand-name drug deductible per person, per calendar year)	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	

Shield Spectrum PPO Plans 500, 750, 1500 and 2000

Covered services <small>(Subject to the plan deductible, unless noted)</small>	Member copayments				
	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%	30%	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
	PPO 500	PPO 750	PPO 1500	PPO 2000	
Mental health services					
Inpatient hospital facility services	\$250/admit + 25%	\$250/admit + 30%	\$250/admit + 30%	\$250/admit + 30%	50% ^{2,3}
Inpatient physician services	25%	30%	30%	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)	25% ⁹	30% ⁹	30% ⁹	30% ⁹	Not covered ⁹
Chemical dependency services <small>(substance abuse)</small>					
Inpatient hospital facility services for medical acute detoxification	\$250/admit + 25%	\$250/admit + 30%	\$250/admit + 30%	\$250/admit + 30%	50% ^{2,3}
Inpatient physician services for medical acute detoxification	25%	30%	30%	30%	50%
Outpatient visits (up to 20 visits per calendar year combined with non-severe mental health visits)	25% ⁹	30% ⁹	30% ⁹	30% ⁹	Not covered ⁹
	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%	30%	30%	Not covered
Other					
Pregnancy and maternity care					
Outpatient prenatal and postnatal care	25%	30%	30%	30%	50%
Delivery and all necessary inpatient hospital services	\$250/admit + 25%	\$250/admit + 30%	\$250/admit + 30%	\$250/admit + 30%	50% ^{2,3}
Family planning					
Consultations, tubal ligation, vasectomy, elective abortion	25%	30%	30%	30%	Not Covered
Rehabilitation services					
Provided in the office of a physician or physical, occupational, or respiratory therapist	25%	30%	30%	30%	50%

Shield Spectrum PPO Plans 500, 750, 1500 and 2000

Covered services (Subject to the plan deductible, unless noted)	Member copayments				With non-preferred providers, ¹ you pay
	With preferred providers, ¹ you pay				
	PPO 500	PPO 750	PPO 1500	PPO 2000	
Chiropractic services (up to 12 visits per calendar year – Blue Shield's payment is limited to \$25.)	50% ●	50% ●	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	30% 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.
- 1 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.
- 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 ambulatory surgery centers may not be available in all areas. Regardless of their availability, you can obtain outpatient surgery services from a hospital, or an ambulatory surgery center affiliated with a hospital with payment according to your health plan's hospital services benefits.
- 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 EOC/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. 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.
- 7 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.
- 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 was 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 2400 (Individual)/4800 (Family) and 4000 (Individual)/8000 (Family)[†] – HSA compatible

[†] 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 Evidence of Coverage and Plan Contract/Policy for Individuals and Families should be consulted for a detailed description of coverage benefits and limitations.

	2400/4800	4000/8000
Deductible*	\$2,400 (\$4,800 Family)	\$4,000 (\$8,000 Family)
Percentage copayment/coinsurance	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.)	\$3,200 (\$5,800 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

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. Adds together applicable expenses accrued by all covered family members.

● Plan benefits provided before you need to meet any medical deductible are shown below with a colored 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 <small>(Subject to the plan deductible, unless noted)</small>	Member copayments		
	With preferred providers, ¹ you pay		With non-preferred providers, ¹ you pay
	2400/4800	4000/8000	
Professional services			
Office visits	30%	No charge after deductible	50%
Preventive care			
Annual routine physical exam, gynecological exam, well-baby care office visits	\$35 ●	\$35 (no charge after deductible) ●	Not covered
Annual Pap test or other approved cervical cancer screening tests and routine mammography, immunizations (with annual physical or in a separate office visit)	30% ●	30% (no charge after deductible) ●	Not covered
Outpatient services (The maximum allowed charges for non-emergency surgery and services performed in a non-participating Ambulatory Surgery Center is \$300 per day. Members are responsible for 50 percent of this \$300 per day, plus all charges in excess of \$300.)			
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) ⁴	30%	No charge after deductible	50% ²
Outpatient X-ray and laboratory	30%	No charge after deductible	50%

Shield Spectrum PPO Savings Plans

Covered services <small>(Subject to the plan deductible, unless noted)</small>	Member copayments		
		With preferred providers, ¹ you pay	With non-preferred providers, ¹ you pay
		2400/4800 4000/8000	
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) ⁵	30%	No charge after deductible	50% ²
Emergency health coverage			
Emergency room services (\$75 copayment 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 and non-participating pharmacies (Up to a 30-day supply)	Mail service prescriptions (Up to a 60-day supply)
		2400/4800 4000/8000	2400/4800 and 4000/8000
Prescription drug coverage³ (outpatient – subject to the plan medical deductible.)	30%	No charge after deductible	Covered at same level as participating and non-participating pharmacies
		With preferred providers,¹ you pay	With non-preferred providers,¹ you pay
		2400/4800 4000/8000	
Durable medical equipment⁶	30%	No charge	50%
		With MSA participating providers,^{1,7} you pay	With MSA non-participating providers,^{1,7} you pay
Mental health services			
Inpatient hospital facility services	30%	No charge after deductible	50% ²
Inpatient physician services, outpatient visits for severe mental health conditions	30%	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)	30%	No charge after deductible	Not covered

Shield Spectrum PPO Savings Plans

Covered services <small>(Subject to the plan deductible, unless noted)</small>	Member copayments		
		With MHSA participating providers, ^{1,7} you pay	With MHSA non-participating providers, ^{1,7} you pay
		2400/4800	4000/8000
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)	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)	30%	No charge after deductible	Not covered
Other			
Pregnancy and maternity care			
Outpatient prenatal and postnatal care	30%	Not covered	50% (not covered for PPO Savings Plan 4000/8000)
Delivery and all necessary inpatient hospital services	30%	Not covered	50% ² (not covered for PPO Savings Plan 4000/8000)
Family planning			
Consultations, tubal ligation, vasectomy, elective abortion	30%	No charge after deductible	Not covered
Rehabilitation services			
Provided in the office of a physician or physical, occupational, or respiratory therapist	30%	No charge after deductible	50%
Chiropractic services (up to 12 visits per calendar year) (member is responsible for all charges over \$25/visit)	50% up to \$25	No charge after deductible	Not covered
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



Shield Spectrum PPO Savings Plans 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 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 Member pays full price and submits prescription drug claims to Blue Shield of California. Prescription coverage differs for home self-injectables. Please review the EOC/Policy before you purchase the plan.
- 4 Participating ambulatory surgery centers may not be available in all areas. Regardless of their availability, you can obtain outpatient surgery services from a hospital, or an ambulatory surgery center affiliated with a hospital with payment according to your health plan's hospital services benefits.
- 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 EOC/Policy for further benefit details.
- 6 For PPO Savings Plan 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 health care service plan to act as our mental health services administrator (MHSA). The MHSA provides mental health and chemical dependency services, other than inpatient services for medical acute detoxification, through a separate network of MHSA participating providers. Inpatient medical acute detoxification is a medical benefit provided by Blue Shield preferred or non-preferred (not MHSA) providers.

HMO plans:

- Access+ Value HMO
- Access+ HMO

HMO Plans

Our affordable HMO plans offer a cost-efficient way to manage your health care, especially if you or your dependents visit the doctor often.

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



Money-back guarantee:

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

Access+ Value HMO 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.
- Virtually no claim forms.
- Knowledgeable customer service representatives who can assist you and quickly answer your questions.

Personal care from your Personal Physician

Your relationship with the Personal Physician you choose is the key to your HMO plan.

He or she:

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

Special features

Direct access to specialists

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

This is only an overview of the Blue Shield Access+ Value HMO and Access+ HMO plans. Please read this information so you will know from whom or what group of providers you can obtain health care. For complete information on the provisions of the Access+ Value HMO and Access+ HMO health plan, please read the plan's *Evidence of Coverage* (EOC). We will be happy to provide you with a copy when you call **(800) 431-2809**.

Access+ Value HMO and Access+ HMO Plan

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 (The calendar year copayment maximum includes the plan deductible (the copayments indicated with ∞ do not apply toward the out-of-pocket maximum amount)	\$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 36, 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 colored dot.

Covered services ¹	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+ <i>Specialist</i> (self-referred physician office visits or other consultations only) ²	\$50/visit* ●	\$35/visit* ●
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 – Non-Emergency		
Outpatient surgery (in a hospital)	40%/visit	\$250/visit
Outpatient surgery performed in an Ambulatory Surgery Center (ASC) ³	\$50/visit	\$35/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

Access+ Value HMO and Access+ HMO Plan

Covered services ¹	Member copayments	
	Access+ Value HMO	Access+ HMO
Emergency health coverage		
Emergency room services (copayment 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 ●
	Access+ Value HMO and Access+ HMO	
Prescription drug coverage^{4,5} (brand-name drugs subject to a \$400/\$200 brand-name drug deductible)	At participating pharmacies (Up to a 30-day supply)	Mail service prescriptions (up to a 60-day supply)
Generic drugs	\$10/prescription* ●	\$20/prescription* ●
Formulary brand-name drugs	\$35/prescription*	\$70/prescription*
	Access+ Value HMO	Access+ HMO
Durable medical equipment⁶	50%* ●	50%* ●
Mental health services⁷		
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* if provider is MHSA Access+ Specialist provider) ² ●	\$20/visit (\$35/visit* if provider is MHSA Access+ Specialist provider) ² ●
Outpatient visits for non-severe mental health conditions (up to 20 visits per calendar year combined with chemical dependency visits)	\$35/visit∞ (\$50/visit* if provider is MHSA Access+ Specialist provider) ² ●	\$20/visit* (\$35/visit* if provider is MHSA Access+ Specialist provider) ² ●
Chemical dependency services (substance abuse) ⁷		
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)	\$35/visit* (\$50/visit* if provider is MHSA Access+ Specialist provider) ² ●	\$20/visit* (\$35/visit* if provider is MHSA Access+ Specialist provider) ² ●
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 care⁸		
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, ⁹ 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) ¹⁰	\$50/visit ●	\$50/visit ●
Dental services (for details please see the Dental Highlights Matrix, page 46)		
Access+ Dentist	Not covered	Included within this plan



Access+ Value HMO and Access+ 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.
- ∞ These copayments do not apply to the out-of-pocket maximum.
- 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 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 towards 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.
- 3 Participating ambulatory surgery centers may not be available in all areas. Regardless of their availability, you can obtain outpatient surgery services from a hospital, or an ambulatory surgery center affiliated with a hospital with payment according to your health plan's hospital services benefits.
- 4 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.
- 5 If a member or the physician requests a brand-name drug when an equivalent generic drug is available, the member pays the generic copayment plus the cost difference between the brand and generic drug at retail or mail order pharmacies.
- 6 All covered orthotic equipment and services have a benefit maximum of \$2,000 per member per calendar year, except those services covered under the diabetes care benefit.
- 7 Blue Shield of California has contracted with a specialized health care service plan to act as the plan's mental health services administrator (MHSA) and to provide mental health and 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.
- 8 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.
- 9 The tubal ligation copayment does not apply when the procedure is performed in conjunction with delivery or abdominal surgery.
- 10 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.

A Health Savings Account adds value to your plan

Our Shield Spectrum PPO Savings Plans 2400/4800 and 4000/8000 are high-deductible health plans that can be paired with a Health Savings Account (HSA), which can offer qualified members* the opportunity to save on taxes. These affordable plans can help you take a more active role in your healthcare choices.

What is an HSA?

HSAs are personal savings or investment accounts that you combine with a high-deductible health plan. The money in your account is not subject to taxation, and you can use the funds 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 in either the PPO Savings Plan** 2400/4800 or 4000/8000 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.

* Please note that most 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 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, within the meaning of Section 223 of the Internal Revenue Code of 1986, as amended.

Important information regarding HSAs

Blue Shield has designed the PPO Savings Plans 2400/4800 and 4000/8000 to meet government requirements for a high-deductible health plan, which would permit qualified individuals to open a tax-advantaged HSA. If you are eligible, you may be able to take advantage of the income tax benefits available when you establish an HSA and use the money you put into it to pay for qualified medical expenses subject to the deductibles under this plan.

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 adviser 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).

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 services, programs, tools, and information to support our members' health. These valuable services are available only to our members.

Lifepath Advisers

*Lifepath Advisers*SM provides a convenient resource that Blue Shield members can consult for immediate professional assistance with virtually any concern, personal or professional. When you become a member, these services are available to you automatically, without any extra cost or paperwork.

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

- **Nurseline.** Registered nurses offer medical information, assistance in choosing the most appropriate type of health care, self-care tips, and lifestyle counseling. Members can also chat online with a registered nurse by logging on to the **Health and Wellness** section of **blueshieldca.com**.
- **Personal consultation.** Master's-level counselors offer support with issues like marriage and relationships, finding a balance between career and personal life, and mental health.
- **Work-life resources.** Sometimes you need help managing the impact of home and career. *Lifepath Advisers* offers a broad range of services, including senior care, child care, family and relationship service, and even financial counseling and legal advice.



Discount Vision Program

When you use MESVision providers in the Discount Vision Program¹, you will receive a 20 percent discount on the following services and supplies:

- Routine eye examinations
- Frames and lenses
- Photochromatic 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 get up to 25 percent 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.

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.

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

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 GuideSM:** Compare inpatient services and their costs at hospitals in your area, and find out about the treatment options for a diagnosed condition.
- **Find a Provider:** Find physicians, dentists, optometrists, chiropractors, hospitals, clinics, and other healthcare providers. You can search by name, specialty, gender, location, or medical group. You can even print directions.
- **Pharmacy:** Send your questions about prescriptions and over-the-counter drugs to a pharmacist at the University of California, San Francisco, and receive your answer within two business days. Check for drugs listed in the formulary. Compare the costs of generic versus brand-name drugs and research drug interaction. Find a participating pharmacy near you.
- **Health and 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.



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.

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.

additional coverage

Dental coverage

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

Dental coverage

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

Monthly Dental Coverage Rates		
	Dental PPO	Dental HMO
Individual (adult or YouthCare SM)	\$35	\$17
Two-party	\$70	\$34
Family	\$110	\$55

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 dental HMO, your health plan and dental coverage effective dates must be the first of the month. (No benefits are paid for services received before the effective date.)



Tip: With the Blue Shield Dental PPO Plan, you have the freedom to choose any dental provider, but your out-of-pocket costs for covered services are lowest when you receive care from participating (network) dentists.

Blue Shield Dental PPO plan

- An extensive network of general care and specialty dentists.
- An individual deductible of \$50 per member per calendar year.
- A wide range of dental benefits, including diagnostic and preventive services at no out-of-pocket cost.
- Coverage even when you use a non-network dentist. (The plan reimburses you for up to a specified amount, and you pay the balance of the total billed charges.)
- A \$1,000 per-member per-year benefit maximum – including a \$500 per-member per-year maximum for out-of-network benefits. (Each calendar year, you're responsible for all charges incurred after the plan has paid these amounts for covered dental services.)
- No waiting period for diagnostic or preventive services. The following waiting periods do apply: Three months for minor restorative services and procedures (such as fillings), endodontics, periodontics, and oral surgery; and 12 months for major restorative services and procedures (such as crowns), orthodontics, and removable and fixed prosthetics.
- All Blue Shield dental PPO plans offer an enhanced benefit for pregnant women that includes an additional teeth cleaning. When necessary, this enhanced benefit includes periodontal maintenance and periodontal scaling and root planing covered at 100 percent of the negotiated rate in network, and 100% of charge for out of network.

Blue Shield Dental HMO plan

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

- An extensive network of general care and specialty dentists.
- No deductibles or calendar-year maximums.
- A wide range of dental benefits, including most diagnostic and preventive services at no out-of-pocket cost to you.
- Specialty care available with a referral from your dental provider.
- No waiting period for any type of service other than orthodontics, which has a 12-month waiting period.
- Virtually no claim forms.

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

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

It's easy to enroll

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

If you are signing up for the Blue Shield Dental HMO, please be sure to list a dental provider for yourself and your family on your application.

Tip: If you do not have a copy of Blue Shield's dental HMO provider directory, please visit the *Find a Provider* section of [blueshieldca.com](https://www.blueshieldca.com) or call **(800) 431-2809**.



Dental PPO and Dental HMO highlights matrix

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

Service	Dental PPO ^{1,2}		Dental HMO ^{3,4}	Access+ <i>Dentist</i>
	With participating dentists, you pay:	With non-participating dentists, the plan reimburses you up to:	You pay:	(Access+ HMO members only) ⁵ You pay:
Diagnostic services				
Comprehensive oral exams	\$0	\$40	\$0	\$20 (plus \$10 for full-mouth series X-rays)
Preventive care				
Prophylaxis (cleanings, every 6 months)				
Adult	\$0	\$48	\$0	\$20
Child	\$0	\$34	\$0	\$20
Sealant/per tooth⁶ (covered to age 16)	\$0	\$22	\$11	\$10
Restorative services²				
One-surface amalgam (filling)	\$35	\$28	\$15	80%**
Crown (porcelain fused to noble metal)	\$320	\$256	\$300*	80%**
Endodontics²				
Anterior root canal	\$156	\$125	\$155	80%**
Molar root canal	\$234	\$187	\$290	Not covered
Periodontics²				
Osseous surgery/per quadrant	\$263	\$210	\$303	Not covered
Periodontal root planing/per quadrant	\$65	\$52	\$75	80%**
Prosthetics²				
Bridge (per unit)	\$293	\$234	\$300*	80%**
Complete denture (upper or lower)	\$388	\$310	\$400	80%**
Oral surgery²				
Extraction (erupted tooth or exposed root)	\$40	\$32	\$34	80%**
Removal of impacted tooth (complete bony)	\$113	\$90	\$125	Not covered
Orthodontics^{2,4,7}				
Fully banded (two year) case – child	\$2,350***	Not covered	\$2,350***	Not covered
Fully banded (two year) case – adult	\$2,650***	Not covered	\$2,650***	Not covered

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

2 Dental PPO members have certain waiting periods: three months for minor restorative services and procedures (such as fillings), endodontics, periodontics, and oral surgery; 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 dental provider, 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 Orthodontic services have a fixed patient copayment and do not apply to your \$1,000 in-network plan maximum.

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

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

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

Life insurance

Individual term life coverage

If you'd like to add the financial protection and security of \$10,000, \$30,000, \$60,000, or \$90,000 in term life insurance to your coverage portfolio, Blue Shield of California Life & Health Insurance Company offers a simple solution.

Applying for term life coverage couldn't be easier. Just complete the life insurance part of your Blue Shield health plan application by checking the box for the amount of life insurance coverage you want, and designate your beneficiary. If coverage is approved, your health plan and life insurance effective dates will be the same, and you'll receive a single combined bill for payment of monthly rates.

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

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**. If coverage is approved, your life insurance effective date will be the first day of the month following approval.

Please note: Individual term life insurance is underwritten by 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 with in-force policies who turn age 50 are eligible to keep their coverage until age 65.

