

Combined Summary of Benefits and Disclosure

Effective July 1, 2006



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Individual and Family Plans

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

Please read this booklet and the EOC/Policy completely and carefully. If you have special healthcare needs, be sure to read the applicable sections of this summary and the EOC/Policy before applying for coverage.

PLEASE NOTE: This brochure 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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*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 plan.

FINDING THE RIGHT PLAN

MAKE THE RIGHT DECISION TODAY:

PROTECT YOUR WELL-BEING WITH BLUE SHIELD HEALTH COVERAGE.

Quality healthcare coverage you can count on matters. As a Blue Shield member, you have coverage from a trusted organization that has provided affordable, flexible and dependable healthcare plans to millions of Californians.

YOU CAN'T AFFORD TO BE WITHOUT HEALTH COVERAGE.

LET US SHOW YOU WHY.

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

An Example of Your Potential Savings for a Serious Accident

The chart below shows the medical costs that could be incurred after a serious motor vehicle accident. The costs include the following:

- Ground service (ambulance)
- Trauma, includes activation fee for trauma team, assuming a designated trauma facility (ER)
- Two broken limbs
- Internal Injuries (includes surgeon, co-surgeon, anesthesia) (ER surgery)
- Five days, semi-private (hospitalization)
- Pain reducers, antibiotics (5 days supply) (generic Rx)
- Physical therapy 3 times/week for 6 weeks
- Non-power wheelchair rental/standard crutches

We've also listed the costs you could pay and the percentage you would save if you have coverage through one of our plans. As a Blue Shield plan member, the costs would be a small portion of what you would pay if you were uninsured.

HYPOTHETICAL ACCIDENT

Services Rendered	Uninsured Billed Amount	Your Costs			
		Shield Spectrum PPO Plan 5000*	Shield Spectrum PPO Savings Plan 2400	Access+ Value HMO	Active Start Plan 25*
Deductible	N/A	\$5,000	\$2,400	\$2,000	\$0
Total Medical Costs	\$140,185	\$7,050	\$3,200	\$4,300	\$6,050
Annual Monthly Rates	N/A	\$1,128	\$1,464	\$2,628	\$1,776
Your Total Costs**	\$140,185	\$8,178	\$4,664	\$6,928	\$7,826
% Savings	N/A	94%	97%	95%	94%

Please note: These costs are estimates based on 2005 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.

WHICH PLAN IS RIGHT FOR YOU?

Everyone has their own unique health coverage needs. Whatever your situation, we have a plan that fits. The chart below shows the features offered by our different plans and can help point you to the coverage that's right for you. Use the information as a guide to make the best choice, based on your needs.

Which Plan is Right For You?													
Features	Active Start Plan 25*	Active Start Plan 35*	Essential Plan 3000*	Essential Plan 4500*	Shield Spectrum PPO Savings Plan 2400	Shield Spectrum PPO Savings Plan 4000*	Shield Spectrum PPO 5000*	Shield Spectrum PPO 2000*	Shield Spectrum PPO 1500*	Shield Spectrum PPO 750	Shield Spectrum PPO 500	Access+ Value HMO	Access+ HMO
Individual-Only Coverage	X	X	X	X									
Annual Medical Deductible			X	X	X	X	X	X	X	X	X	X	X
HSA-Compatible					X	X							
Chiropractic Coverage					X	X		X	X	X	X		
Maternity Coverage					X		X	X	X	X	X	X	X
Dental Benefits			X	X									X
Vision Benefits			X	X									
Brand Name Rx Coverage	X	X			X	X	X	X	X	X	X	X	X
Preventive Care not subject to the Deductible	N/A	N/A	X	X	X	X	X	X	X	X	X	X	X

*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 3000 and Essential Plan 4500 are subject to regulatory approval.

PLAN COMPARISON CHART Take the first step toward protecting yourself and your family with healthcare coverage.

YOUR HEALTH PLAN OPTIONS	PPO Plans				
	Individual-Only Plans				Shield PPO SM 4000
	Active Start SM Plan 35 [†]	Active Start SM Plan 25 [†]	NEW! Essential SM Plan 3000 [†]	NEW! Essential SM Plan 4500 [†]	
This plan may be right for you if you want:	Single-party coverage with low monthly premiums and no calendar-year medical deductible.		Economical single-party coverage including dental and vision benefits; annual deductible equals the out-of-pocket maximum to help you contain costs.		Affordable to your budget when you need it.
Annual medical deductible	No Individual Deductible	No Individual Deductible	\$3,000 Individual	\$4,500 Individual	\$4,000 Individual \$8,000 Family
Total calendar-year out-of-pocket costs with preferred providers (includes plan deductible) ²	\$7,500 Individual Copayment Maximum	\$6,000 Individual Copayment Maximum	\$3,000 Individual Copayment Maximum Note: Annual deductible accrues to the Copayment Maximum	\$4,500 Individual Copayment Maximum Note: Annual deductible accrues to the Copayment Maximum	\$4,000 Individual out-of-pocket Note: Annual deductible accrues to the Copayment Maximum
ALL COPAYMENTS/COINSURANCES LISTED BELOW ARE THE MEMBER'S RESPONSIBILITY					
Preventive care					
Annual physical exam, well-baby care, gynecological exam	\$35	\$25	\$40	\$40	\$35 (unless then No charge)
Pap test, approved cervical cancer screening, mammography, pediatric/adult immunizations	Covered by the copay when performed as part of the Preventive Care visit.	Covered by the copay when performed as part of the Preventive Care visit.	Covered by the copay when performed as part of the Preventive Care visit.	Covered by the copay when performed as part of the Preventive Care visit.	No charge
Professional services					
Physician office visits	\$35	\$25	\$40 ⁴ (until deductible is met then No charge)	\$40 ⁴ (until deductible is met then No charge)	No charge
Hospital inpatient (non-emergency)	\$500/admit + 40%	\$500/admit + 40%	No charge	No charge	No charge
Maternity services (resulting in delivery)	Not covered	Not covered	Not covered	Not covered	Not covered
Outpatient services (non-emergency)					
Surgery	\$500/admit + 40%	\$500/admit + 40%	No charge	No charge	No charge
X-ray and laboratory	40%	40%	No charge	No charge	No charge
ER services					
Emergency Room visits	\$35/visit ³ + 40%	\$25/visit ³ + 40%	\$100 ³	\$100 ³	No charge
Ambulance	40%	40%	No charge	No charge	No charge
ER physician visits/consultations	\$35	\$25	No charge	No charge	No charge
Prescription benefits					
Generic	\$10/Rx	\$10/Rx	\$10/Rx	\$10/Rx	No charge
Formulary brand-name drugs	\$35/Rx (after \$750 brand-name deductible)	\$35/Rx (after \$500 brand-name deductible)	Not covered	Not covered	You will contractually participating meeting eligible then at participating
Non-formulary brand-name drugs	\$50 or 50% (whichever is greater)/Rx (after \$750 brand-name deductible)	\$50 or 50% (whichever is greater)/Rx (after \$500 brand-name deductible)	Not covered	Not covered	

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

Please Note: Benefits shown as shaded in the gray boxes 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.

[†] 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.

verage. Use this chart to compare our different health plans and find the one that works best for you.

PPO Plans				
HSA-Compatible Plans				
Shield Spectrum PPO SM Savings Plan 1500/8000 [†]	Shield Spectrum PPO SM Savings Plan 2400/4800	Shield Spectrum PPO SM Plan 5000 [†]	Shield Spectrum PPO SM Plan 2000 [†]	Shield Spectrum PPO SM Plan 750
<p>able coverage for high-cost event; annual deductible applies to out-of-pocket maximum payment; possible tax savings combined with an HSA.</p>		<p>Low-cost coverage for high-cost event with added security of <i>Critical Condition ProtectionSM</i> (CCP) – a \$10,000 payout if, as a member, you are diagnosed with a critical condition as defined by the plan.</p>	<p>Choice of annual deductible: the higher the deductible, the lower the plan's monthly dues. Freedom to choose your own providers each time you seek care. Preventive care coverage is available before having to meet the plan deductible. Blue Shield also offers Shield Spectrum PPOSM Plan 1500[†] and Shield Spectrum PPOSM Plan 500. Please contact your authorized agent or Blue Shield for more information.</p>	
\$0 Individual	\$2,400 Individual	\$5,000 Individual	\$2,000 Individual	\$750 Individual
\$0 Family [#]	\$4,800 Family [#]	\$10,000 Family	\$4,000 Family	\$1,500 Family
\$0 (\$8,000 family) out-of-pocket costs	\$3,200 (\$5,800 family) out-of-pocket costs	\$7,000 (\$14,000 family) Copayment Maximum	\$5,000 (\$10,000 family) Copayment Maximum + \$2,000 (\$4,000 family) Deductible = \$7,000 (\$14,000 family) out-of-pocket costs	\$4,000 (\$8,000 family) Copayment Maximum + \$750 (\$1,500 family) Deductible = \$4,750 (\$9,500 family) out-of-pocket costs
Annual deductible accrues to the Out-of-Pocket Maximum	Note: Annual deductible accrues to the Out-of-Pocket Maximum	Note: Annual deductible accrues to the Copayment Maximum		
Until deductible is met (no charge)	\$35	\$35	\$45	\$35
Charge	30%/service	Covered by the copay when performed as part of the Preventive Care visit.	Covered by the copay when performed as part of the Preventive Care visit.	Covered by the copay when performed as part of the Preventive Care visit.
Charge	30%	\$35	\$45	\$35
Charge	30%	30%	30%	30%
Covered	30%	30%	30%	30%
Charge	30%	30%	30%	30%
Charge	30%	30%	30%	30%
Charge	\$75/visit ³ + 30%	30%/visit	30%/visit	30%/visit
Charge	30%	30%	30%	30%
Charge	30%	30%	30%	30%
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	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	\$10/Rx	\$10/Rx	\$10/Rx
		\$35/Rx (after \$500 brand-name deductible)	\$35/Rx (after \$500 brand-name deductible)	\$35/Rx (after \$250 brand-name deductible)
		\$50 or 50% (whichever is greater)/Rx (after \$500 brand-name deductible)	\$50 or 50%, whichever is greater (\$150 max/Rx) (after \$500 brand-name deductible)	\$50 or 50%, whichever is greater (\$150 max/Rx) (after \$250 brand-name deductible)

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 only applies to facility charges for inpatient hospital services, outpatient hospital surgery services, skilled nursing facility services, hospice program services, and ambulatory surgery center services.

Plan Comparison and footnotes continued on next page

PLAN COMPARISON CHART continued...

HMO Plans	
Access+ Value HMO SM	Access + HMO [®]
Many covered services right away for a fixed copayment; virtually no claim forms to file; predictable out-of-pocket costs throughout the year.	
\$2,000 Individual ¹	\$2,000 Individual ¹
\$4,000 Family ¹	\$4,000 Family ¹
\$4,000 (\$8,000 family) Copayment Maximum Note: Annual deductible accrues to the Copayment Maximum	\$3,000 (\$6,000 family) Copayment Maximum Note: Annual deductible accrues to the Copayment Maximum
ALL COPAYMENTS/COINSURANCES LISTED BELOW ARE THE MEMBER'S RESPONSIBILITY	
Preventive care	
\$35	\$20
\$35 (No charge for pediatric/adult immunizations)	\$20 (No charge for pediatric/adult immunizations)
Professional services	
\$35	\$20
40%/admit	\$250/admit
40%/admit	\$250/admit
Outpatient services (non-emergency)	
40%/visit	\$250/visit
\$35/visit	\$20/visit
ER services	
\$150/visit ³	\$75/visit ³
\$50/trip	\$50/trip
No charge	No charge
Prescription benefits	
\$10/Rx	\$10/Rx
\$35/Rx (after \$400 brand-name deductible)	\$35/Rx (after \$200 brand-name deductible)
Not covered (except w/prior authorization)	Not covered (except w/prior authorization)

² HMO Plans, Shield Spectrum PPO Savings Plans 2400/4800 and 4000/8000, Essential Plan 3000 and Essential Plan 4500, and Shield Spectrum PPO Plan 5000: the out-of-pocket/copayment maximums include the plan deductible. Shield Spectrum PPO Plans 2000-500: The copayment maximum does not include the plan deductible. 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 the first three 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 3000 and Essential Plan 4500 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 Individual and Families* for a more complete description of the benefits, terms and conditions, and limitations of the health plans.

FREQUENTLY ASKED QUESTIONS

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

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

With an HMO plan, you:

- Generally pay higher monthly rates so that your costs are lower whenever you access care throughout the year
- 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
- Live or work in an HMO service area (identified in Blue Shield's HMO Directory)

With a PPO plan, you:

- Choose your own provider(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 any applicable plan deductible
- Reduce your out-of-pocket costs when you use Blue Shield's or Blue Shield Life's preferred provider network – a network of more than 350 hospitals and over 45,000 doctors



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

Each of our PPO plans has a different calendar-year deductible and different benefit levels. In general, the higher the calendar-year deductible for a plan, the lower the monthly rates. Plans with lower deductibles tend to have higher monthly rates, more generous prescription drug benefits and lower office visit copayments. Two of our PPO plans, Active Start Plan 25 and Active Start Plan 35, have no medical deductible.

Another key difference is that the Active Start plans and Essential plans 3000 and 4500 offer individual coverage only. This means that there are no two-party or family coverage options for these four plans.

In addition, five plans do not include maternity benefits. These are the Active Start plans, the Essential plans 3000 and 4500 and Shield Spectrum PPO Savings Plan 4000/8000.

Please see pages 18-27 for a description of all your PPO plan choices and to review each plan's benefit summary for more detail.

Is preventive care covered?

Yes. To help our members stay healthy, Blue Shield health plans cover preventive care such as routine physical exams, immunizations, well-baby care and annual gynecological exams before meeting any deductible.

Is my doctor part of a Blue Shield provider network?

Blue Shield offers some of the largest HMO and PPO networks in California. You can find out whether your doctor participates by going to the Find a Provider section of our Web site, mylifepath.com. You'll find every practitioner in the extensive Blue Shield and Blue Shield Life networks, including hospitals. You'll also be able to locate dentists, optometrists, dermatologists, mental health providers, chiropractors and acupuncturists.

Can individual family members have different plans?

Yes. It may better suit some families' health coverage needs or budget to place family members on different types of plans. Putting your child on his or her own plan with special YouthCareSM rates may also save you money when compared against having a single family plan. Your agent will be able to guide you and discuss which plan may be right for each of your family members – don't forget to ask about YouthCare rates.

How do deductibles work?

Your health plan may have a deductible. You must satisfy this amount each year before Blue Shield makes payments towards covered services. Depending on your plan design, some services, such as preventive care, may be covered by Blue Shield before your deductible is met. See your EOC/Policy for more details.

In addition, if your plan has a deductible and you have family coverage, a family

deductible applies. Blue Shield family deductibles are calculated by adding together the total amount of deductible met per person in a family. Each individual's deductible is satisfied once the family deductible is met. For example, if the family deductible is equal to twice the individual deductible, and two people in the family satisfy their deductible, then the deductible is satisfied for all family members covered under the plan for the remainder of the calendar year.

Can I get dental coverage through Blue Shield?

Yes. If you're a Blue Shield member, you have the opportunity to purchase the Dental PPO or Dental HMO dental plan for an additional cost.

In addition, several medical plans offer dental coverage at no extra charge. These include the new Essential plans 3000 and 4500, and the Access+ HMO plan (offers Access+ *Dentist*SM). Please see page 31 for details.

Can I get life insurance through Blue Shield?

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

Please Note: The Active Start Plan 25 and 35, Essential Plan 3000 and 4500, Blue Shield Life PPO Plans 1500 and 2000, Shield Spectrum PPO Plan 5000 and Shield Spectrum PPO Savings Plan 4000/8000 are underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

ACTIVE START PLANS

Get value from day one with our no deductible Active Start plans.



Are you looking for individual coverage that is affordable and allows easier access to care with low monthly rates and no annual medical deductible?

If your answer is “yes,” then consider one of our Active Start plans. Both include dependable coverage with a full network of providers, so you can choose the doctor you want to see.

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

Active Start Plan advantages

- You choose the copayment that best fits your budget \$25 or \$35
- No medical deductible to meet, so your coverage starts immediately
- \$25/\$35 copayments for preventive care office visits and \$10 copayments for generic prescription drugs at participating pharmacies
- Benefits for alternative care like chiropractic and acupuncture
- One of the largest provider networks in the state
- Affordable coverage for individuals

How is an Active Start Plan different?

Active Start differs from most of our plans in that it is individual-only coverage and does not provide maternity benefits. Active Start also features no medical deductible, low generic drug copayments and low copayments for office visits and preventive care in one affordable PPO plan. If affordability has prevented you from having healthcare coverage, you may want to consider an Active Start plan.

ACTIVE START PLANS 25 AND 35

Uniform Health Plan Benefits & Coverage Matrix

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

ACTIVE START PLANS		
These plans are underwritten by Blue Shield of California Life & Health Insurance Company.		
	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
PERCENTAGE COPAYMENTS	40% with Preferred Hospitals 50% with Non-Preferred Providers	40% with Preferred Hospitals 50% with Non-Preferred Providers
CALENDAR-YEAR COPAYMENT/COINSURANCE MAXIMUM (Some services do not apply)	Services with Preferred Providers: \$6,000 Individual only Services with All Providers: \$8,000	Services with Preferred Providers: \$7,500 Individual only 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			
– Non-Emergency services and procedures	40%	40%	50% ^{2,3}
– Outpatient surgery in hospital	\$500/admit + 40%	\$500/admit + 40%	50% ^{2,3}
– Outpatient or Out-of-Hospital X-ray and Laboratory	40%	40%	50%

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	
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}
EMERGENCY HEALTH COVERAGE			
– Outpatient Emergency room facility services, semiprivate room and board, services and supplies, and subacute care not resulting in admission (\$25/\$35 copayment waived if the member is admitted directly to the hospital as an inpatient)	\$25/visit + 40%	\$35/visit + 40%	\$25/\$35/visit + 40%
– ER Physician visits	\$25	\$35	\$25/\$35
AMBULANCE SERVICES (Surface or Air)	40%	40%	40%
Active Start Plans 25 and 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			
	Active Start Plan 25	Active Start Plan 35	With Non-Preferred Providers,¹ you pay
DURABLE MEDICAL EQUIPMENT⁵	40%	40%	50%
With MHA Participating Providers,^{1,6} you pay			
	With MHA Participating Providers,^{1,6} you pay		With MHA Non-Participating Providers,^{1,6} 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

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	
HOME HEALTH SERVICES (up to 90 preauthorized visits per calendar year)	40%	40%	Not Covered
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)			
– Physical, occupational, or respiratory therapy	40%	40%	50% (up to a maximum payment of \$25/visit)
Chiropractic Services (up to 12 visits per calendar year combined with Rehabilitation Services and Speech Therapy visits)	40%	40%	50% (up to a maximum payment of \$25/visit)
Acupuncture (up to 12 visits per calendar year combined with Acupressure)	50% (up to a maximum payment of \$25/visit)	50% (up to a maximum payment of \$25/visit)	50% (up to a maximum payment of \$25/visit)
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. Members are responsible for all charges that exceed \$250 per day.
- 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 home 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.

ESSENTIAL PLAN 3000 AND 4500

New! These low-cost individual-only plans minimize your annual out-of-pocket costs and offer the broad range of quality coverage you need.



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. EssentialSM Plan 3000 and 4500 provide the affordable quality coverage you need and limit your possible out-of-pocket costs. The plans are available for individuals only and do not provide maternity or brand-name drug benefits.

Are you looking for a health plan that limits the total annual amount you may have to spend on copayments and deductibles, includes dental and vision coverage, and also has affordable monthly rates?

If your answer is "yes", then consider one of our new Essential plans. They offer dependable coverage with a full network of providers, so you can choose your doctor. And both plans 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)
- LASIK discount program*
- Choice of two deductibles (\$3,000 and \$4,500)
- Access to one of the largest provider networks in California

* This discount program is not part of our vision plans and is offered in addition to the benefits covered under the vision plans. Members who are not satisfied with services received under the discount program may use the Blue Shield of California or Blue Shield Life (as applicable) grievance process. Blue Shield reserves the right to terminate this program without notice.

ESSENTIAL PLAN 3000 AND ESSENTIAL PLAN 4500

Uniform Health Plan Benefits & Coverage Matrix

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

ESSENTIAL PLANS 3000 and 4500 These plans are underwritten by Blue Shield of California Life & Health Insurance Company.		
	Essential Plan 3000	Essential Plan 4500
DEDUCTIBLE	\$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
CALENDAR-YEAR COPAYMENT/COINSURANCE MAXIMUM (Includes the plan deductible. Some services do not apply.)	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

Essential plan benefits provided before you need to meet the deductible are shown in a shaded box. For all benefits without shading, you are responsible for all charges up to the allowable amount or billed charges 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
	Essential Plan 3000	Essential Plan 4500	
PROFESSIONAL SERVICES			
– Office visits (First 3 visits per calendar year. Subsequent visits are subject to the deductible.)	\$40 (until deductible is met then No Charge)	\$40 (until deductible is met then No Charge)	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	Not Covered
OUTPATIENT SERVICES			
– Non-Emergency services and procedures	No Charge	No Charge	50% ^{2,3}
– Outpatient surgery in hospital	No Charge	No Charge	50% ^{2,3}
– Outpatient or Out-of-Hospital X-ray and Laboratory	No Charge	No Charge	50%

COVERED SERVICES (Subject to the plan deductible, unless noted)	MEMBER COPAYMENTS		
	With Preferred Providers, ¹ you pay		With Non-Preferred Providers, ¹ you pay
	Essential Plan 3000	Essential Plan 4500	
HOSPITALIZATION SERVICES			
– Inpatient physician visits and consultations, surgeons and assistants, and anesthesiologists	No Charge	No Charge	50%
– Inpatient semiprivate room and board, services and supplies, and subacute care	No Charge	No Charge	50% ^{2,3}
EMERGENCY HEALTH COVERAGE			
– Outpatient Emergency room facility services, semiprivate room and board, services and supplies, and subacute care not resulting in admission (\$100 copayment waived if the member is admitted directly to the hospital as an inpatient)	\$100 ²	\$100 ²	\$100 ²
– ER Physician visits	No Charge	No Charge	No Charge
AMBULANCE SERVICES (Surface or Air)	No Charge	No Charge	No Charge
Essential Plans 3000 and 4500			
PRESCRIPTION DRUG COVERAGE⁴ (outpatient)	At Participating Pharmacies (Up to a 30-day supply)		Mail Service Prescriptions (Up to a 60-day supply)
– Generic formulary drugs	\$10/prescription ²		\$20/prescription ²
– Formulary brand-name drugs	Not Covered		Not Covered
– Non-formulary brand-name drugs	Not Covered		Not Covered
	With Preferred Providers, ¹ you pay		With Non-Preferred Providers, ¹ you pay
	Essential Plan 3000	Essential Plan 4500	
DURABLE MEDICAL EQUIPMENT⁵	No Charge	No Charge	50%
	With MHA Participating Providers, ¹⁶ you pay		With MHA Non-Participating Providers, ¹⁶ you pay
MENTAL HEALTH SERVICES			
– Inpatient Hospital Facility Services	No Charge	No Charge	50% ^{2,3}
– Inpatient Physician Services	No Charge	No Charge	50%
– Outpatient visits for severe mental health conditions (First 3 visits per calendar year. Subsequent visits subject to the deductible)	\$40 (until deductible is met then No Charge)	\$40 (until deductible is met then No Charge)	50%
– Outpatient visits for non-severe mental health conditions (up to 20 visits per calendar year combined with chemical dependency visits)	No Charge	No Charge	Not Covered
CHEMICAL DEPENDENCY SERVICES (Substance Abuse)			
– Inpatient Hospital Facility Services for medical acute detoxification	No Charge	No Charge	50% ^{2,3}
– Inpatient Physician Services for medical acute detoxification	No Charge	No Charge	50%
– Outpatient visits (up to 20 visits per calendar year combined with non-severe mental health visits)	No Charge	No Charge	Not Covered

COVERED SERVICES (Subject to the plan deductible, unless noted)	MEMBER COPAYMENTS		
	With Preferred Providers ¹ , you pay		With Non-Preferred Providers ¹ , you pay
	Essential Plan 3000	Essential Plan 4500	
HOME HEALTH SERVICES (up to 90 preauthorized visits per calendar year)	No Charge	No Charge	Not Covered
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	No Charge	No Charge	Not Covered
Rehabilitation Services (up to 20 visits per calendar year combined with Speech Therapy visits)			
– Physical, occupational, or respiratory therapy	No Charge	No Charge	50%
Chiropractic Services	Not Covered	Not Covered	Not Covered
Out-of-State Services (Plan benefits covered nationwide with the BlueCard program)	No Charge with BlueCard participating provider	No Charge with BlueCard participating provider	50% with all other providers
DENTAL SERVICES⁷			
Preventive and diagnostic (Including routine oral exams, X-rays and cleaning)	No Charge	No Charge	All charges above the allowable amount
Minor restorative (Not subject to medical deductible. Subject to \$50 dental deductible. Including amalgam and resin based fillings.)	\$35 - \$100	\$35 - \$100	Member reimbursed per procedure reimbursement schedule
VISION SERVICES⁸			
Vision exam	\$5 ²	\$5 ²	\$5 ²

Please Note: Benefits are subject to modification for subsequently enacted state or federal legislation. Essential Plan 3000 and Essential Plan 4500 are subject to regulatory approval.

¹ Member is responsible for copayment or coinsurance in addition to any charges above allowable amounts. The coinsurance indicated is a percentage of the allowable amounts. Preferred providers accept Blue Shield allowable amounts as payment-in-full for covered services. Non-preferred providers can charge more than these amounts. When members use non-preferred providers, they must pay the applicable copayment or coinsurance plus any charges that exceed Blue Shield's allowable amount. Charges above the allowable amount do not count toward the copayment/coinsurance maximum.

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

³ For non-emergency hospital services and supplies received from a non-preferred hospital, Blue Shield's payment is limited to \$250 per day. Members are responsible for all charges that exceed \$250 per day.

⁴ Prescription coverage differs for Home Self-Injectables. Please review the Policy before you purchase the plan.

⁵ All covered orthoses have a combined benefit maximum of \$500 per member per calendar year. All covered prosthetics have a combined benefit maximum of \$2,000 per member per calendar year. See Policy for details.

⁶ 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.

⁷ Dental services provided through Dental Benefit Providers (DBP). Benefits limited to \$500 per calendar year. Three month waiting period following the effective date of coverage for minor restorative services.

⁸ Vision exam provided through MESVision network.

SHIELD SPECTRUM PPO SAVINGS PLANS AND SHIELD SPECTRUM PPO PLANS

Choose one of our PPO plans with the calendar-year deductible and benefits that work best for you, including four that are HSA-compatible.



Do you want protection against major healthcare expenses with the potential for tax savings?

If your answer is “yes,” consider one of our Shield Spectrum PPO Savings Plans. They are highly affordable plans that offer many advantages while keeping monthly rates low. Please note that the Shield Spectrum PPO Savings Plan 4000/8000 does not offer maternity benefits.

Shield Spectrum PPO Savings Plan advantages

- Blue Shield offers four High-Deductible Health Plans (HDHPs) that are designed to be compatible with a Health Savings Account (HSA). To learn more about the tax advantages of HSAs, turn to page 34 or call (800) 431-2809
- Choose a plan with the coverage levels you need – 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 on a fixed copayment basis before meeting any deductible
- Get prescription drugs at our contracted rate at participating pharmacies
- Access to a mail service pharmacy benefit
- 100 percent coverage for prescription drugs once the out-of-pocket maximum for the plan has been satisfied
- Family deductibles are calculated by adding together the total amount of deductible met per person in a family

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

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

Shield Spectrum PPO Plan advantages

- One of California’s largest PPO provider networks: over 45,000 doctors and more than 350 hospitals
- Many services with a fixed dollar or percentage copayment before you meet the annual deductible
- Wide range of annual deductibles – and when two or more people are covered, each covered individual in the family has his or her own individual deductible, in case only one person needs expensive medical care.
- Copayment/coinsurance maximums to help contain costs – your family copayment maximums are only twice the individual amounts, no matter how many people are covered on the plan
- Added protection of \$10,000 in *Critical Condition Protection*SM (CCP) with the PPO Plan 5000*

**Critical Condition Protection* (CCP) is part of the Shield Spectrum PPO Plan 5000. Members who have a first incident of severe heart attack, severe stroke or certain life-threatening cancer 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 advisor.

SHIELD SPECTRUM PPO SAVINGS PLAN 2400 (INDIVIDUAL)/4800 (FAMILY)

HSA – COMPATIBLE

Uniform Health Plan Benefits & Coverage Matrix

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

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

PPO Savings Plan benefits provided before you need to meet the deductible are shown in a shaded box. For all benefits without shading, you are responsible for all charges up to the allowable amount or billed charges 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	30%		50%
PREVENTIVE CARE			
– Annual Routine Physical Exam, Gynecological Exam, Well-Baby care office visits	\$35		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%/service		Not Covered
OUTPATIENT SERVICES			
– Non-emergency services and procedures, Outpatient surgery in a hospital	30%		50% ²
– Outpatient 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
EMERGENCY HEALTH COVERAGE			
– Emergency room services (\$75 copayment waived if the member is admitted directly to the hospital as an inpatient)	\$75/visit + 30%		\$75/visit + 30%
– ER Physician visits	30%		30%
AMBULANCE SERVICES (Surface or Air)	30%		30%
PRESCRIPTION DRUG COVERAGE⁵ (outpatient; subject to the plan deductible)	At Participating Pharmacies (Up to a 30-day supply) 30%	At Non-Participating Pharmacies (Up to a 30-day supply) 30%	Mail Service Prescriptions (Up to a 60-day supply) 30%

COVERED SERVICES (Subject to the plan deductible, unless noted)	MEMBER COPAYMENTS	
	With Preferred Providers, ¹ you pay	With Non-Preferred Providers, ¹ you pay
DURABLE MEDICAL EQUIPMENT³	30%	50%
	With MSA Participating Providers, ^{1,4} you pay	With MSA Non-Participating Providers, ^{1,4} you pay
MENTAL HEALTH SERVICES		
– Inpatient Hospital Facility Services	30%	50% ²
– Inpatient Physician Services, Outpatient visits for severe mental health conditions	30%	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
– 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 preauthorized 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
Family Planning		
– Consultations, tubal ligation, vasectomy, elective abortion	30%	Not Covered
Rehabilitation Services		
– Physical, occupational, or respiratory therapy	30%	50%
Chiropractic Services (up to 12 visits per calendar year)	50% up to \$25 (member is responsible for all charges over \$25/visit)	Not Covered
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.

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 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, Home Medical Equipment or the Diabetes Care benefit.

4 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.

5 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 before you purchase the plan.

SHIELD SPECTRUM PPO SAVINGS PLAN 4000 (INDIVIDUAL)/8000 (FAMILY)

HSA – COMPATIBLE

Uniform Health Plan Benefits & Coverage Matrix

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

SHIELD SPECTRUM PPO SAVINGS PLAN 4000/8000

This plan is underwritten by Blue Shield of California Life & Health Insurance Company.

DEDUCTIBLE*	\$4,000 Individual/\$8,000 Family	
CALENDAR-YEAR OUT-OF-POCKET MAXIMUM (Includes the plan deductible.) Please Note: The deductibles and out-of-pocket maximum amounts may increase annually to reflect federal cost-of-living adjustment.	Services with Preferred Providers:	\$4,000 Individual/\$8,000 Family
	Services with All Providers:	\$5,000 Individual/\$10,000 Family
LIFETIME MAXIMUM	\$6,000,000	

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

PPO Savings Plan benefits provided before you need to meet the deductible are shown in a shaded box. For all benefits without shading, you are responsible for all charges up to the allowable amount or billed charges 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	No Charge		50%
PREVENTIVE CARE			
– Annual Routine Physical Exam, Gynecological Exam, Well-Baby care office visits	\$35 (until deductible is met, then No Charge)		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)	No Charge		Not Covered
OUTPATIENT SERVICES			
– Non-emergency services and procedures, Outpatient surgery in a hospital	No Charge		50% ²
– Outpatient X-ray and laboratory	No Charge		50%
HOSPITALIZATION SERVICES			
– Inpatient physician visits and consultations, surgeons and assistants, and anesthesiologists	No Charge		50%
– Inpatient semiprivate room and board, services and supplies, and subacute care	No Charge		50% ²
EMERGENCY HEALTH COVERAGE			
– Emergency room services	No Charge		No Charge
– ER Physician visits	No Charge		No Charge
AMBULANCE SERVICES (Surface or Air)			
	No Charge		No Charge
PRESCRIPTION DRUG COVERAGE⁵ (outpatient; subject to the plan deductible)			
	At Participating Pharmacies (Up to a 30-day supply)	At Non-Participating Pharmacies (Up to a 30-day supply)	Mail Service Prescriptions (Up to a 60-day supply)
	No Charge	No Charge	No Charge

COVERED SERVICES (Subject to the plan deductible, unless noted)	MEMBER COPAYMENTS	
	With Preferred Providers, ¹ you pay	With Non-Preferred Providers, ¹ you pay
DURABLE MEDICAL EQUIPMENT³	No Charge	50%
	With MHSa Participating Providers,^{1,4} you pay	With MHSa Non-Participating Providers,^{1,4} you pay
MENTAL HEALTH SERVICES		
– Inpatient Hospital Facility Services	No Charge	50% ²
– Inpatient Physician Services, Outpatient visits for severe mental health conditions	No Charge	50%
– Outpatient visits for non-severe mental health conditions (up to 20 visits per calendar year combined with chemical dependency visits)	No Charge	Not Covered
CHEMICAL DEPENDENCY SERVICES (Substance Abuse)		
– Inpatient Hospital Facility Services for medical acute detoxification	No Charge	50% ²
– Inpatient Physician Services for medical acute detoxification	No Charge	50%
– Outpatient visits (up to 20 visits per calendar year combined with non-severe mental health visits)	No Charge	Not Covered
	With Preferred Providers,¹ you pay	With Non-Preferred Providers,¹ you pay
HOME HEALTH SERVICES (up to 90 preauthorized visits per calendar year)	No Charge	Not Covered
OTHER		
Pregnancy and Maternity Care		
– Outpatient prenatal and postnatal care	Not Covered	Not Covered
– Delivery and all necessary inpatient hospital services	Not Covered	Not Covered
Family Planning		
– Consultations, tubal ligation, vasectomy, elective abortion	No Charge	Not Covered
Rehabilitation Services		
– Physical, occupational, or respiratory therapy	No Charge	50%
Chiropractic Services (up to 12 visits per calendar year)	No Charge (member responsible for all charges over \$25/visit)	Not Covered
Out-of-State Services (full plan benefits covered nationwide with the BlueCard program)	No Charge 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's allowable amount as payment-in-full for covered services. Non-preferred providers can charge more than the allowable amounts. When members use non-preferred providers, they must pay the applicable copayment or coinsurance plus any charges that exceed Blue Shield's allowable amount. Charges above the allowable amount do not count toward the plan deductible or the calendar year out-of-pocket maximum.
- 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.
- All covered home 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.
- 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.
- Member pays full price and submits prescription drug claims to Blue Shield of California Life & Health Insurance Company. Prescription coverage differs for Home Self-Injectables. Please review the Policy before you purchase the plan.

SHIELD SPECTRUM PPO PLAN 5000

Uniform Health Plan Benefits & Coverage Matrix

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

SHIELD SPECTRUM PPO PLAN 5000 This plan is underwritten by Blue Shield of California Life & Health Insurance Company.		
DEDUCTIBLE*	\$5,000 (\$10,000 Family)	
COPAYMENTS	\$35 with Preferred Providers Not applicable with Non-Preferred Providers	
COINSURANCE	30% with Preferred 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 PROTECTION	\$10,000 per member, per lifetime	
* Benefits for covered brand-name drugs are subject to a separate \$500 brand-name drug deductible per person.		

Plan benefits that are available before you need to meet the medical plan deductible are shown below in a shaded box. For all benefits without shading, you are responsible for all charges up to the allowable amount or billed charges 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		
– Non-Emergency services and procedures, Outpatient surgery in a hospital	30%	50% ^{2,3}
– 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}
EMERGENCY HEALTH COVERAGE		
– Outpatient Emergency room facility services, semiprivate room and board, services and supplies, and subacute care not resulting in admission	30%/visit	30%/visit
– ER Physician visits	30%	30%
AMBULANCE SERVICES (Surface or Air)	30%	30%

COVERED SERVICES	MEMBER COPAYMENTS	
(Subject to the plan deductible, unless noted)	With Preferred Providers, ¹ you pay	With Non-Preferred Providers, ¹ you pay
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
DURABLE MEDICAL EQUIPMENT⁵	30%	50%
	With MHA Participating Providers,^{1,6} you pay	With MHA Non-Participating Providers,^{1,6} 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 preauthorized 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)		
– Physical, occupational, or respiratory therapy	30%	50%
Out-of-State Services (full plan benefits covered nationwide with the BlueCard program)	30% with BlueCard Participating Providers	50% with all other providers

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

- 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 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.
- 5 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.
- 6 Blue Shield has contracted with a specialized health care service plan to act as our mental health services administrator (MHA). The MHA provides mental health and chemical dependency services, other than inpatient services for medical acute detoxification, through a separate network of MHA participating providers. Inpatient medical acute detoxification is a medical benefit provided by Blue Shield preferred or non-preferred (not MHA) providers.

SHIELD SPECTRUM PPO PLANS 500 TO 2000

BLUE SHIELD LIFE PPO PLANS 1500 AND 2000

Uniform Health Plan Benefits & Coverage Matrix

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

Blue Shield of California and Blue Shield of California Life & Health Insurance Company each offers a PPO Plan 2000 and 1500. Please call (800) 431-2809 for more information.

SHIELD SPECTRUM PPO PLANS		
	PPO 500/750	PPO 1500/2000
DEDUCTIBLE*	\$500/\$750 (\$1,000/\$1,500 Family)	\$1,500/\$2,000 (\$3,000/\$4,000 Family)
COPAYMENTS	\$30/\$35 with Preferred Providers Not applicable with Non-Preferred Providers	\$40/\$45 with Preferred Providers Not applicable with Non-Preferred Providers
PERCENTAGE COPAYMENTS	25%/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/\$4,000 (\$7,000/\$8,000 Family) Services with All Providers: \$5,000/\$6,000 (\$10,000/\$12,000 Family)	Services with Preferred Providers: \$4,500/\$5,000 (\$9,000/\$10,000 Family) Services with All Providers: \$6,500/\$7,000 (\$13,000/\$14,000 Family)
LIFETIME MAXIMUM	\$6,000,000	\$6,000,000
TOTAL ANNUAL OUT-OF-POCKET COSTS	Deductible + copayment maximum	Deductible + copayment maximum
* 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 that are available before you need to meet the medical plan deductible are shown below in a shaded box. For all benefits without shading, you are responsible for all charges up to the allowable amount or billed charges 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
	PPO 500/750	PPO 1500/2000	
PROFESSIONAL SERVICES			
– Office visits	\$30 ² / \$35 ²	\$40 ² / \$45 ²	50%
PREVENTIVE CARE			
– Annual Routine Physical Exam, Well-Baby care office visits and Gynecological exam (includes Pap test or other approved cervical cancer screening tests, routine mammography, and immunizations when received as part of the annual exam or preventive care visit)	\$30 ² / \$35 ²	\$40 ² / \$45 ²	Not Covered
OUTPATIENT SERVICES			
– Non-Emergency services and procedures, Outpatient surgery in hospital	25% / 30%	30%	50% ^{2,3}
– Outpatient or Out-of-Hospital X-ray and Laboratory	25% / 30%	30%	50%
HOSPITALIZATION SERVICES			
– Inpatient physician visits and consultations, surgeons and assistants, and anesthesiologists	25% / 30%	30%	50%
– Inpatient semiprivate room and board, services and supplies, and subacute care	25% / 30%	30%	50% ^{2,3}

COVERED SERVICES (Subject to the plan deductible, unless noted)	MEMBER COPAYMENTS		
	With Preferred Providers, ¹ you pay		With Non-Preferred Providers, ¹ you pay
	PPO 500/750	PPO 1500/2000	
EMERGENCY HEALTH COVERAGE			
– Outpatient Emergency room facility services, semiprivate room and board, services and supplies and subacute care not resulting in admission	25%/visit / 30%/visit	30%/visit	Covered at same level as Preferred Provider
– ER Physician visits	25% / 30%	30%	Covered at same level as Preferred Provider
AMBULANCE SERVICES (Surface or Air)	25% / 30%	30%	Covered at same level as Preferred Provider
For PPO Plans 500 to 2000			
PRESCRIPTION DRUG COVERAGE⁴ (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	
	With Preferred Providers, ¹ you pay	With Non-Preferred Providers, ¹ you pay	
	PPO 500/750	PPO 1500/2000	
DURABLE MEDICAL EQUIPMENT⁵	25% / 30%	30%	50%
	With MHSA Participating Providers, ^{1,6} you pay		With MHSA Non-Participating Providers, ^{1,6} you pay
MENTAL HEALTH SERVICES			
– Inpatient Hospital Facility Services	25% / 30%	30%	50% ^{2,3}
– Inpatient Physician Services	25% / 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% / 30%	30%	Not Covered
CHEMICAL DEPENDENCY SERVICES (Substance Abuse)			
– Inpatient Hospital Facility Services for medical acute detoxification	25% / 30%	30%	50% ^{2,3}
– Inpatient Physician Services for medical acute detoxification	25% / 30%	30%	50%
– Outpatient visits (up to 20 visits per calendar year combined with non-severe mental health visits)	25% / 30%	30%	Not Covered
	With Preferred Providers, ¹ you pay	With Non-Preferred Providers, ¹ you pay	
HOME HEALTH SERVICES (up to 90 preauthorized visits per calendar year)	25% / 30%	30%	Not Covered
OTHER			
Pregnancy and Maternity Care			
– Outpatient prenatal and postnatal care	25% / 30%	30%	50%
– Delivery and all necessary inpatient hospital services	25% / 30%	30%	50% ^{2,3}

COVERED SERVICES

MEMBER COPAYMENTS

(Subject to the plan deductible, unless noted)

With Preferred Providers,¹ you pay

With Non-Preferred Providers,¹ you pay

	PPO 500/750	PPO 1500/2000	
Family Planning – Consultations, tubal ligation, vasectomy, elective abortion	25% / 30%	30%	Not Covered
Rehabilitation Services – Physical, occupational or respiratory therapy	25% / 30%	30%	50%
Chiropractic Services (up to 12 visits per calendar year)	50% up to \$25 (member responsible for all charges over \$25)	50% up to \$25 (member responsible for all charges over \$25)	Not Covered
Out-of-State Services (full plan benefits covered nationwide with the BlueCard program)	25% / 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.

- Member is responsible for fixed dollar or percentage copayment or coinsurance in addition to any charges above allowable amounts. The coinsurance/copayment percentage indicated is a percentage of the allowable amounts. Preferred providers accept Blue Shield allowable amounts as payment-in-full for covered services. Non-preferred providers can charge more than these amounts. When members use non-preferred providers, they must pay the applicable copayment percentage of the allowable amount or coinsurance plus any charges that exceed Blue Shield's allowable amount. Charges above the allowable amount do not count toward the plan deductible or copayment/coinsurance maximum.
- These copayments do not count toward the copayment/coinsurance maximum and will continue to be charged once it is reached.
- For non-emergency hospital services and supplies received from a non-preferred hospital, Blue Shield's payment is limited to \$250 per day. Members are responsible for all charges that exceed \$250 per day.
- 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/Rx for non-formulary brand-name drugs does not apply to Blue Shield Life Shield Spectrum PPO Plans 2000 or 1500. Prescription coverage differs for Home Self-Injectables. Please review the EOC/Policy before you purchase the plan.
- All covered orthotic equipment and services have a benefit maximum of \$2,000 per member per calendar year, except those services covered under the Diabetes Care benefit.
- 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.

BLUE SHIELD HMO PLANS

Choose one of our HMO plans for an easy and efficient way to manage your health care and your costs.



Personal care from your Personal Physician

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

- Provide or coordinate your necessary medical services
- Arrange for referrals to specialists and hospitals and other covered non-physician healthcare practitioners

Special features of the HMO plans

Self-referral to specialists

With Access+ *Specialist*SM you can go directly to a specialist or other physician in the same medical group or IPA as your Personal Physician, without a referral. When you self-refer, your copayment will be \$35/\$50 per covered office visit (depending on which plan option you select). To use the Access+ *Specialist* option, you must belong to a medical group or IPA that is an Access+ *Specialist* provider group.

Do you or your dependents go to the doctor often?

If your answer is "yes," an HMO plan could be right for you. You'll have access to a wide range of routine and preventive care services for a small copayment, without having to meet a deductible. Also, Access+ Value HMO offers you a lower-cost option while providing the convenience of our full HMO provider network.

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

Access+ Value HMO and Access+ HMO plan advantages

- \$20/\$35 office visit copayments; \$10 copayments for generic drug prescriptions
- See a specialist without a referral in your Personal Physician's participating medical group/IPA for a \$35/\$50 copayment
- Our full HMO network has more than 25,000 doctors and 280 hospitals throughout California
- YouthCare rates make the plan more affordable for the entire family
- Basic dental services with Access+ HMO
- No lifetime maximum on plan benefits
- Virtually no claim forms

Self-referrals to gynecological exams and OB/GYN visits

Women may go directly to an OB/GYN or family practice physician in the same medical group or IPA as their Personal Physician for obstetrical/gynecological services – including annual gynecological exams – without a referral.

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.

NOTE: 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 health care may be obtained. For complete information on the provisions of the Access+ Value HMO and Access+ HMO health plans, 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 & 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.

HMO PLANS		
	Access+ Value HMO	Access+ HMO
DEDUCTIBLE*	\$2,000 (\$4,000 Family)	\$2,000 (\$4,000 Family)
CALENDAR-YEAR OUT-OF-POCKET MAXIMUM The calendar year copayment maximum includes the plan deductible (The copayments indicated with ∞ do not apply towards 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. The brand-name drug deductibles are as follows: 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 28, services that are not obtained from or approved by your Personal Physician will not be covered.

Benefits that are available before you meet any deductible are shown in a shaded box.

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/visit	\$35/visit
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 Services and Supplies (in a hospital; includes radiation and intravenous chemotherapy)	40%/visit	\$35/visit
HOSPITALIZATION SERVICES		
– Inpatient physician visits and consultations, surgeons and assistants, and anesthesiologists (covered inpatient hospital, skilled nursing facility and subacute care physician services)	\$35/visit	\$20/visit
– Inpatient semiprivate room and board, intensive care units, subacute care, special treatment rooms, services and supplies	40%/admit	\$250/admit
EMERGENCY HEALTH COVERAGE		
– Emergency room services (copayment waived if the member is admitted directly to the hospital as an inpatient)	\$150/visit	\$75/visit
– Inpatient hospital services and supplies	40%/admit	\$250/admit
AMBULANCE SERVICES (Surface or Air)	\$50/trip	\$50/trip
Access+ Value HMO and Access+ HMO		
PRESCRIPTION DRUG COVERAGE^{3,4} (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 [∞]

COVERED SERVICES ¹	MEMBER COPAYMENTS	
	Access+ Value HMO	Access+ HMO
DURABLE MEDICAL EQUIPMENT⁵	50% [∞]	50% [∞]
MENTAL HEALTH SERVICES⁸		
– Inpatient Hospital Facility Services	40%/admit	\$250/admit
– Inpatient Physician Services	\$35/visit	\$20/visit
– Outpatient visits for severe mental health conditions ²	\$35/visit (\$50/visit [∞] if provider is MHSA Access+ <i>Specialist</i> provider)	\$20/visit (\$35/visit [∞] if provider is MHSA Access+ <i>Specialist</i> provider)
– Outpatient visits for non-severe mental health conditions (up to 20 visits per calendar year combined with chemical dependency visits) ²	\$35/visit [∞] (\$50/visit [∞] if provider is MHSA Access+ <i>Specialist</i> provider)	\$20/visit [∞] (\$35/visit [∞] if provider is MHSA Access+ <i>Specialist</i> provider)
CHEMICAL DEPENDENCY SERVICES (Substance Abuse)⁸		
– Inpatient hospital facility services for medical acute detoxification	40%/admit	\$250/admit
– Outpatient visits (up to 20 visits per calendar year combined with non-severe mental health visits) ²	\$35/visit [∞] (\$50/visit [∞] if provider is MHSA Access+ <i>Specialist</i> provider)	\$20/visit [∞] (\$35/visit [∞] if provider is MHSA Access+ <i>Specialist</i> provider)
HOME HEALTH SERVICES (up to 100 visits per calendar year)		
– Home Health Agency visits (up to 4 visits per day, 2 hours per visit)	\$35/visit	\$20/visit
OTHER		
Pregnancy and Maternity Care⁶		
– 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, ⁷ 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 a hospital outpatient department	\$35/visit	\$20/visit
– In Inpatient rehabilitation unit of hospital	40%/admit	\$250/admit
Urgent Care (outside your Plan Service Area)⁹	\$50/visit	\$50/visit
Dental Services (for details please see the Dental Highlights Matrix, page 32)		
– Access+ <i>Dentist</i>	Not Covered	Embedded within this Plan

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

[∞] 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 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.
- 4 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.
- 5 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.
- 6 Except for the treatment of involuntary complications of pregnancy, pregnancy/maternity benefits for a pregnancy that qualifies as a Waivered Condition are not available during the six-month period beginning as of the effective date of coverage.
- 7 The tubal ligation copayment does not apply when the procedure is performed in conjunction with delivery or abdominal surgery.
- 8 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 substance abuse services, members should access MHSA participating providers.
- 9 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.

DENTAL COVERAGE

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

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

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.)

Dental Coverage

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

The Blue Shield Dental PPO Plan

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

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

year, the member is responsible for all charges incurred after the plan has paid these amounts for covered dental services.)

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

The Blue Shield Dental HMO Plan

With the Blue Shield Dental HMO Plan, you choose a dental provider from our list of Blue Shield Dental HMO dental providers. 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, and generally lower copayments than the Dental PPO.
- Specialty care available with a referral from your dental provider.

- No waiting period for any type of service other than orthodontics. (A 12-month waiting period applies to orthodontic services.)
- 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. Although Access+ *Dentist* is included in the health plan, Access+ HMO members can choose to purchase a more generous dental plan instead of receiving the Access+ *Dentist* services.

We've made it 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. If you do not have a copy of Blue Shield's *Dental HMO Dental Provider Directory*, please visit the Find a Provider section of our Web site at mylifepath.com or call (800) 431-2809.

DENTAL PPO AND DENTAL HMO HIGHLIGHTS MATRIX

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

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

INDIVIDUAL TERM LIFE INSURANCE

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

MONTHLY INDIVIDUAL TERM LIFE INSURANCE RATES

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

* Those 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.

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 Blue Shield at **(800) 431-2809** or downloading it from **bscalife.com**. If coverage is approved, your life insurance effective

date will be the first day of the month following approval.

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

ADDING MORE VALUE TO YOUR PLAN WITH A HEALTH SAVINGS ACCOUNT

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) that offers qualified members* the opportunity to save on taxes. Our HSA-eligible high-deductible health plans enable you to receive benefits at lower-cost monthly rates while taking a more active role in your healthcare choices.

What is an HSA?

HSAs are tax-advantaged personal savings or investment accounts intended for payment of qualified medical expenses that may be established in combination with qualifying high-deductible health plans. HSAs offer a number of benefits compared to other tax-advantaged accounts:

- Higher contribution limits than Archer Medical Savings Accounts (MSAs) or most Flexible Spending Accounts (FSAs)
- Broader eligibility guidelines
- Both employees and employers may contribute in the same year
- Catch-up contributions are allowed for people ages 55 to 65
- Portability: Members own and control the accounts even if they change jobs

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 that may not be covered by your health plan, including dentist visits, eye exams and even acupuncture. You can also accumulate tax-free funds from year to year for future healthcare funding such as long-term care.

Preferred HSA administrator delivers convenience and cost savings

To provide you with a one-stop HSA experience, Blue Shield has carefully researched and selected Wells Fargo as the preferred administrator to manage HSAs for our members with HSA-eligible high-deductible health plans. As a Blue Shield member, you will benefit from no transaction fees, low monthly administration fees and the comprehensive customer service offered by Wells Fargo. However, you may establish an HSA with any financial institution who offers an HSA.

To get more information about the Health Savings Account offered by Wells Fargo, please call (866) 890-8313.

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 tax-advantaged Health Savings Accounts (HSAs). If you are eligible, it may allow you to take advantage of the income tax benefits available when you establish an HSA and use the money you put into the HSA to pay for qualified medical expenses subject to the deductibles under this plan.

NOTICE: Blue Shield currently has a relationship with an HSA administrator but does not provide tax advice. If you intend to purchase this plan to use with an HSA for tax purposes, you should consult with your tax advisor about whether you are eligible and whether your HSA meets all legal requirements.

Although Blue Shield believes that these plans meet these requirements, the Internal Revenue Service has not ruled on whether the plans are qualified as high-deductible health plans. Should you purchase one of these plans to obtain the income tax benefits associated with an HSA and the Internal Revenue Service were to rule 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, Blue Shield intends to amend the Shield Spectrum PPO Savings Plans, if necessary, to meet the requirements of a qualified plan. A change in the plan's monthly rates may also be required as a result of a change in the plan(s).

* 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.

**As of July 2005, the 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 (HSA), within the meaning of Section 223 of the Internal Revenue Code of 1986, as amended. Blue Shield may receive a nominal referral fee from Wells Fargo Bank when a high-deductible health plan member that has been referred establishes an HSA with Wells Fargo.

ADDITIONAL SERVICES OFFER MORE VALUE WITH EVERY PLAN

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

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. These services are available to you automatically upon becoming a member, without any extra cost or paperwork.

Available 24 hours a day, seven days a week, *Lifepath Advisers* provides 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 My Health Plan section of our Web site, mylifepath.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, lifelong learning – even financial counseling and legal advice.

The MESVision Network Discount Vision Program

When you use MESVision providers,* you will receive a 20 percent discount for a wide range of services and supplies.

Mylifepath Alternative Health Services Discount Program

Through the *Mylifepath*SM Alternative Health Services Discount Program, you can save money on alternative health and wellness services. This program provides members 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 member ID card to any *Mylifepath* network practitioner and paying the lesser of 25 percent off the practitioner's usual published fee or the program's maximum fee schedule.

Mylifepath.com

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

- **My Health Plan:** Find out about your specific plan's benefits and services, view summaries of copayments, coinsurance and annual deductible amounts.
- **Lifepath Decision Guide**SM: 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 prescription and over-the-counter drugs to a pharmacist at the University of California, San Francisco and receive your answer within two business days. Check for drugs listed in the formulary. Compare the costs of generic versus brand-name drugs and research drug interaction. Find a participating pharmacy near you.
- **Health & Wellness:** Search our Health Library for up-to-date information on a wide variety of health topics from expert health sources like the Mayo Clinic. And discover helpful health topics delivered right to your inbox by subscribing to our Health Update e-newsletter.

Health Management Programs

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

* Discount program services are provided by 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.

